

Designing Smiles

Cosmetic and Family Dentistry



◆ W E L C O M E ◆

Thank you for selecting us. Please fill out this form in ink. If you have any questions or need assistance, please ask. We'd be happy to help.

Patient Information (Confidential)

Date _____
Name _____ E-mail Address _____
SS# _____ Birth date _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Preferred contact: Cell Home Work
Check Appropriate Box: Minor Single Married Widowed Divorced Separated
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Patient/Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Person to Contact in Case of Emergency _____ Phone _____
Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ E-mail Address _____
City _____ State _____ Zip _____ Home Phone _____
Driver's License # _____ State _____ Birth date _____ Cell Phone _____
SS# _____ Bank _____ Is this Person Currently a Patient in Our Office? Yes No
Employer _____
Employer's Address _____ City _____ State _____ Zip _____ Work Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birth date _____ SS# _____ Date Employed _____
Name of Employer _____ Employer's Phone _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance Do You Have Additional Insurance?

Yes No
Name of Insured _____ Relationship to Patient _____
Birth date _____ SS# _____ Date Employed _____
Name of Employer _____ Employer's Phone _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy # _____
Insurance Co. Address _____ City _____ State _____ Zip _____