SMILE DENTAL GROUP
Full Service Dentistry

Patient Information Sheet

Office:

Patient Information

Language: ☐ English ☐ Spanish Gender: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Home #: _____ Work #: _____
Cell #: _____ Texting OK? ☐ Yes ☐ No
E-Mail Address: _____
Preferred method of communication:
☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

Responsible Party

Relationship to patient: ☐ Self ☐ Guardian/Parent ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Home #: _____ Work #: _____
Cell #: _____ Texting OK? ☐ Yes ☐ No
E-Mail Address: _____

Employer Information

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed
Employer/School Name: _____
Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ How long? _____Year(s) ____Month(s)

Emergency Contact

Relationship to patient: ☐ Responsible Party ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____
Cell #: _____
Physician Name: _____ Phone #: _____

Patient Name: _____
Chart #: _____ Date: _____

Primary Insurance Information

Insurance Type: ☐ No Insurance ☐ HMO ☐ PPO/Indemnity ☐ Dent-Cal
Plan Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insurance ID #: _____Policy / Group #: _____
Subscriber's Information (Primary Member)
Relationship to Patient: ☐ Self ☐ Responsible Party ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Employer: _____

Secondary Insurance Information

Insurance Type: ☐ No Insurance ☐ HMO ☐ PPO/Indemnity ☐ Dent-Cal
Plan Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insurance ID #: _____Policy / Group #: _____
Subscriber's Information (Primary Member)
Relationship to Patient: ☐ Self ☐ Responsible Party ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Employer: _____

How did you hear about us?

☐ Walk-In	☐ Billboard	☐ Others _____
☐ TV	☐ Family/Friend	_____
☐ Radio	☐ Website	_____
☐ YellowPages	☐ Internet/Insurance	_____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for all charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional corporation or professional association otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize release of any information relating to any dental claim or claims.

You can text Smile Dental for information regarding our services. By texting Smile Dental, you agree to receive Conversations (between employees) messages from Smile Dental. Reply STOP to opt-out; Reply HELP for support. Message & data rates may apply. Messaging frequency may vary. Visit https://www.smiledentalgroup.com/privacy-policy/ to view our Privacy Policy and Terms of Service.

_____ _____
Signature of Responsible Party Date
(Patient or Legal Guardian if patient is a minor)

Patient Information Update Update is noting no major change in Patient Information

Date	Signature	Comments