



SmileStudio

Last Name: _____ First Name: _____ M.I: _____

Address: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____ Work Phone: (____)____-____

DOB: __/__/____ Sex: M/F SSN: _____-____-____ Marital Status: _____

Employer: _____ Occupation: _____

Email Address: _____ Referred By: _____

Preferred Way of Contact : Phone Text Email

Emergency Contact: _____ Telephone Number: _____

Insurance

Primary Insurance Company: _____

Identification Number: _____ Group Number: _____

Primary Policy Holder: _____ DOB: __/__/____ SSN: _____-____-____

Secondary Insurance Company: _____

Identification Number: _____ Group Number: _____

Primary Policy Holder: _____ DOB: __/__/____ SSN: _____-____-____

Responsible For Payment

Name: _____ DOB: __/__/____ SSN: _____-____-____

Address: _____

Primary Contact Number: (____)____-____ Secondary Contact Number: (____)____-____

Employer: _____ Occupation: _____

Relationship to the Patient: _____

I authorize payment directly to Smile Studio for dental services rendered. I understand my responsibility as a patient at Smile Studio. By signing this is acknowledge all information provided above is correct to the best of my knowledge.

Signature (Patient/Guardian): _____