Confidential Dental and Medical History

Patient's Name ______________________ Age ______ DOB ______________

Address ______________________________

City/State/Zip ______________________________

Home Phone ______________________ Mobile ______________________

Work Phone ______________________ Email ______________________

Best Contact: ☐ Email ☐ Mobile ☐ Text ☐ Home Best Time to Reach You ______________

SS# ______________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer ______________________________

Employer Address ______________________________

Spouse's Name ______________________________

Spouse's Phone (Work) ______________________ (Cell) ______________________

Emergency Contact ______________________ Relation __________ Emergency Phone ______________

Do you have dental insurance? ☐ Yes ☐ No If yes, Insurance Carrier's Name ______________

Group # ______________________ Phone ______________ Subscriber's Name ______________

Relation to Patient __________ Subscriber's SS# ______________ Subscriber's DOB __________

Employer/Co. Name ______________________ Phone ______________

Employer/Co. Address, City, State, Zip ______________________________

Insurance Carrier Address, City, State, Zip ______________________________

HOW DID YOU HEAR ABOUT US? ______________________________

Would you like to receive appointment reminders via text message? ☐ Yes ☐ No Email? ☐ Yes ☐ No

Would you like to become friends with Smile Design Studio on Facebook to receive **Special Offers**? ☐ Yes ☐ No

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Smile Design Studio at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service, Any portion of treatment that the Insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (30) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

______________________________ ______________________

Patient or Parent/Guardian Signature *Date*

SMILE DESIGN STUDIO

for the health...for the beauty...of your smile

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