



Patient Information

Name: _____
Last First MI Title
Preferred Name: _____ Male Female
Address: _____ City _____ State _____ ZIP _____
SSN: _____ Birthdate: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Marital Status: Single Married Divorced Widowed Separated Domestic Partner
How did you hear about our office? _____
Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____

Responsible Party Information

Name: _____ Relationship to Patient: _____ DOB: _____
SSN/ID: _____ Employer: _____
Phone Number: _____
Spouse Name: _____ DOB: _____ SSN/ID: _____
Employer: _____

Insurance

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Smile Now Dental all medical and/or dental insurance benefits, or third party payer, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also acknowledge that any account that goes beyond 60 days past due will be transferred to Transworld Systems Inc. for accounts receivable assistance. Should this be necessary, a service fee/rebilling fee will be added to my account of at least \$25. Interest may be applicable. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____