SMILE ASSESSMENT
PATIENT INFORMATION FORM

Patient's Full Legal Name: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Patient Email: _____

Date of Birth: _____ Social Security Number: _____

Primary Dentist: _____ Dentist Phone: _____ Pharmacy Phone: _____

Primary Medical Doctor: _____ Doctor Phone: _____ Pharmacy Fax: _____

Ortho Chart # and Location: _____ Dental Chart # and Location: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____
Last First Middle Initial

Mailing Address: _____

Physical Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security: _____

INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ Social Security: _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Number: _____ Phone Number: _____

Relationship to Patient: _____ Insurance Claims Fax: _____ Effective Date: _____

Insurance Co. Address: _____

SECONDARY INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ Social Security: _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Number: _____ Phone Number: _____

Relationship to Patient: _____ Insurance Claims Fax: _____ Effective Date: _____

Insurance Co. Address: _____

EMERGENCY INFORMATION

Emergency Contact Person: _____

Relationship to Patient: _____ Phone Number: _____

Mailing Address: _____

Signature: _____ Date: _____

I understand that where appropriate, credit bureau reports may be obtained. I understand and agree that I am responsible for payment. I certify this information is true and correct to the best of my knowledge.