SMILE SHOP
NEWTOWN

Who may we thank for referring you to our office? _____

What name would you like to be called in our office? _____

PATIENT INFORMATION

Name: _____
Last Name, First Name, Middle Initial

Single ____
Married ____
Other ____

If in college, is the student a full or part time student and where do they attend college: FT PT

Child (under 21) _____ College: _____

Date of Birth: _____ Sex: M F

Social Security Number: _____

Home Address: _____

_____

_____

E-Mail Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

How would you like us to contact you most frequently:
Home _____ Work _____ Cell _____ E-Mail _____

Name of Employer: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____
Last Name, First Name, Middle Initial

Patient's relation to responsible party: Spouse Parent Other

Responsible Person's Status: Patient Non-Patient

Date of Birth: _____

SS Number: _____

Employer: _____

Home Address: _____

_____

_____

E-Mail: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

How would you like us to contact your most frequently:
Home _____ Work _____ Cell _____ E-Mail _____

PRIMARY DENTAL INSURANCE PLAN

Carrier Name: _____

Group Plan: _____

Address: _____

_____

Phone Number: _____

Identification Number: _____

Group Number: _____

Employer Name: _____

Employer Address: _____

_____

Employer Phone: _____

SECONDARY DENTAL INSURANCE PLAN

Carrier Name: _____

Group Plan: _____

Address: _____

_____

Phone Number: _____

Identification Number: _____

Group Number: _____

Employer Name: _____

Employer Address: _____

_____

Employer Phone: _____

Financial Policy: By signing below, I understand and accept the following financial policy:

1. **If I am using a participating dental insurance, I hereby authorize payment of the dental benefits to this office. I understand that anything not paid by dental insurance will remain my personal responsibility.**
2. **If I am not using a participating dental insurance, I understand that payment is expected at time of service for all dental treatment.**
3. **I understand that balances over 30 days are subject to a 1.5% monthly late fee.**
4. **I understand that any fees incurred for the collection of outstanding balances over 30 days will remain my responsibility.**

_____ _____

Patient Signature Today's Date