ANDREW J. SMITH, DMD

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY:

NAME:_____ DOB:_____

HOME ADDRESS:_____

BILLING ADDRESS:_____

CELL PHONE:_____ WORK PHONE:_____

AGE:_____ MALE:_____ FEMALE:_____

MARITAL STATUS: MARRIED:_____ SINGLE:_____ DIVORCED:_____ WIDOWED:_____

EMPLOYER:_____

IF COVERED BY ANOTHER PERSON'S INSURANCE, PLEASE PROVIDE:

NAME OF POLICY HOLDER:_____

POLICY HOLDERS DOB: _____ POLICY HOLDER'S EMPLOYER:_____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S INFORMATION:

NAME:_____

HOME ADDRESS:_____

CELL PHONE:_____ WORK PHONE:_____

EMPLOYER:_____

IN CASE OF AN EMERGECY:

RELATIVE TO CONTACT:_____

RELATIONSHIP TO PATIENT:_____ PHONE #:_____

ANOTHER PERSON TO CONTACT, OTHER THAN A RELATIVE:_____

RELATIONSHIP TO PATIENT:_____ PHONE #:_____

WHO REFERRED YOU TO OUR OFFICE?_____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

CONSENT: I AM AWARE THAT MY ACCOUNT WILL INCUR A 1.5% FINANCE CHARGE AFTER 90 DAYS. I UNDERSTAND THAT MY INSURANCE IS BILLED AS A COURTESY, THAT I AM RESPONSIBLE TO KNOW MY INSURANCE BENEFITS AND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT, REGARDLESS OF INSURANCE.

SIGNATURE:_____ DATE:_____