

Welcome!

Thank you for choosing the dental team at a Glowing Smile Dental Care. We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please completely fill out this form in ink. If you have any questions or need assistance, please ask us – we are here to help.

Patient Information: (CONFIDENTIAL)

Today's Date: _____

Name _____ Date of Birth ____/____/____ Soc. Sec.# ____-____-____

(Please check one) Patient is: Minor Single Married Divorced Separated

Residential Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ - _____

Mobile Phone (____) _____ - _____

E-mail: _____

(only if different from home address)

Mailing Address _____

City _____ State _____ Zip _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone (____) _____ - _____

Email _____

If Patient is a Full-Time Student: Name of

School/College: _____

City _____ State _____

Person to Contact in Case of an Emergency _____

Phone (____) _____ - _____ Relationship to patient _____

Preferred appointment day(s) MON TUE WED THU FRI

Preferred appointment times: MORNING AFTERNOON EVENING ANYTIME

Responsible Party:

Is the responsible party currently a patient of this office? Yes / No

Responsible Party Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Work Phone (____) _____ - _____

Mobile Phone (____) _____ - _____

Driver's Lic. # _____ State _____

Date of Birth ____/____/____

Soc. Sec.# ____-____-____

Spouse's Name _____

Date of Birth ____/____/____

Soc. Sec.# ____-____-____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone (____) _____ - _____

Mobile Phone (____) _____ - _____

Email _____

Insurance Information:

Insurance Carrier/Plan _____ Group # _____ Subscriber ID. _____

Name of Insured _____ Relationship to Patient _____

Date of Birth ____/____/____ Soc. Sec.# ____-____-____ Employer _____

Claims Mailing Address _____ Annual Deductible \$ _____

City _____ State _____ ZIP _____ - _____ Maximum Annual Benefit \$ _____

Has your deductible been met for the current benefit year? Yes / No

Have you been seen in another dental office in the past year? Yes / No

If yes, were X-rays taken? Yes / No

How did you hear about Glowing Smile Dental Care? Internet Insurance Specialist Flyer Work Other

Name of office or other source referring you to our practice _____