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 fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we are here to help.

Patient Information: *(CONFIDENTIAL)*

Today's Date: _____

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

Name: _____ Preferred name / Nickname: _____
Date of Birth____/_____/_____ Soc. Sec. #_____-____-_____

Residential Address_____
_____ Apartment #_____
City_____ State_____ Zip_____
Home Phone (____)_____-_____
Mobile Phone (____)_____-_____
E-mail: _____
Mailing Address (only if different from home address)
_____
City _____State_____ Zip_____

Employer_____
Employer Address_____
City _____State_____ Zip_____
Work Phone (____)_____-_____
Work Email_____

If Patient is a Full-Time Student: Name of School or College: _____
City_____ State_____

Please list any family members currently patients of our office that should be linked in the same account:
Children under 18: _____
Spouse or other: _____

Person to Contact in Case of an Emergency_____
Phone (____) _____-_____ Relationship to patient_____

Responsible Party

(if patient is under 18 yrs of age that's the person signing the paperwork and bringing them to appointment)

Responsible Party Name _____
Relationship to Patient_____
Address_____
_____Apt # _____
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 us? ☐ Internet search ☐Google ☐ Insurance ☐Specialist ☐Flyer ☐Work ☐Other

Please name the person or source referring you to our practice_____