

WELLCOME TO FOREVER SMILE

Please complete both sides of this form so that we can provide you with the best possible care.

1. PATIENT INFORMATION			DATE:
PATIENT'S NAME:	LAST	FIRST	M.I.
WHAT WOULD YOU LIKE TO BE CALLED BY?		OCCUPATION	
HOME STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE NO.	WORK	CELL	
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> MINOR
		SOCIAL SECURITY _ _ _ _ _	
E-MAIL	DATE OF BIRTH	AGE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
IF THIS APPOINTMENT IS FOR A MINOR (UNDER 18 YEARS OLD) STATE YOUR FULL NAME AND RELATIONSHIP TO THE PATIENT:			

2. DENTAL INSURANCE AND ACCOUNT INFORMATION	
PRIMARY CARRIER:	SRCONDARY CARRIER
INSURANCE COMPANY	INSURANCE COMPANY
EMPLOYER NAME	EMPLOYER NAME
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
SUBSCRIBER'S SOCIAL SECURITY NO.	SUBSCRIBER'S SOCIAL SECURITY NO.
ID #	ID #
GROUP #	GROUP #
DATE OF BIRTH	RELATIONSHIP TO PATIENT
PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
NAME:	RELATIONSHIP TO PATIENT: SOCIAL SECURITY NO. _ _ _ _ _
ADDRESS: _____	
PHONE NO. _____	

3. PLEASE LET US KNOW	
IS ANY OF YOUR FAMILY MEMBER OR RELATIVE A PATIENT OF OURS? NAME	RELATIONSHIP
HOW DID YOU FIND US? <input type="checkbox"/> INTERNET <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> INSURANCE <input type="checkbox"/> MAIL <input type="checkbox"/> REFERRAL	
WHOM MAY WE THANK FOR REFERING YOU? _____	

(Please complete the other side)