Happy Smiles Dental

PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form.

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Sex: ◯ Male ◯ Female

Date of Birth: _____ / _____ / _____ Age: _____ Soc. Sec. #: _____

Email: _____ ◯ I would like to receive correspondence via email & text

Employer: _____ Occupation: _____

How did you find our office? ◯ Google ◯ Passed by ◯ Insurance ◯ Other: _____

Where have you referred by another office? Name: _____

Your Preferred Pharmacy: Name: _____ Phone Number _____

Pharmacy Address: _____

PRIMARY DENTAL INSURANCE INFORMATION

◯ No Insurance. I will pay myself

Policy Holder Name: _____

Relationship to Patient ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

Policy Holder DOB: _____ / _____ / _____ Policy Holder Soc. Sec. #: _____

Insurance Company: _____ Plan Type: ◯ PPO ◯ Medicaid

Insurance ID #: _____ Insurance Tel: _____

_____	_____	_____
PATIENT'S NAME	PATIENT'S SIGNATURE (IF OVER 18)	DATE
_____	_____	_____
GUARDIAN'S NAME	GUARDIAN'S SIGNATURE	DATE