Sterling Smiles DENTAL

PATIENT INFORMATION

NAME: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S EMPLOYER: _____

CITY: _____ STATE: _____

IF PT IS A STUDENT, NAME OF SCHOOL: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MAY WE CONTACT YOU VIA EMAIL OR TEXT: YES NO

CONFIDENTIAL

BIRTHDATE: _____

SSN: _____

CIRCLE APPROPRIATE SELECTION:

MINOR MARRIED WIDOWED

DIVORCED SINGLE SEPARATED

WORK PHONE: _____

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

CIRCLE ONE: TEXT EMAIL BOTH

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT FROM ABOVE:

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PT: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

BIRTHDATE: _____

SSN: _____

INSURANCE INFORMATION

NAME OF INSURED: _____

INSURANCE COMPANY : _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE: _____

RELATIONSHIP TO PT: _____

BIRTHDATE: _____

SSN: _____

GROUP NUMBER: _____

SUBSCRIBER ID: _____