



Our goal is to provide you and your family with the finest dental care available. Our philosophy revolves around the finest quality of dental treatment. The reason, we believe your teeth should last a lifetime. Our comprehensive approach involves a complete dental evaluation, utilizing the latest techniques with your specific concerns in cosmetics, orthodontics, TMJ, restorative and preventative needs in mind.



# HEAVENLY SMILES DENTAL

## PATIENT INFORMATION:

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOMEPHONE: (\_\_\_\_) \_\_\_\_\_ CELLULAR: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_ SEX: **M** **F**

**EMAIL ADDRESS:** \_\_\_\_\_ (Level of communication = Level of Success)

Your Previous/Present Dentist Name and Phone#: \_\_\_\_\_ Last Visit: 6 Months 12Months I want to get better. YES

## EMERGENCY CONTACT INFORMATION:

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

CONTACT PHONE: (\_\_\_\_) \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**\*whom may we thank for referring you to our office?**

FLYER  INTERNET  OTHER: \_\_\_\_\_

Love the location Enter for in office GAME >>>> **FRIEND OR FAMILY** (please print name): \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION: (if patient is a minor)

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOMEPHONE: \_\_\_\_\_ CELLULAR: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION:

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_ SEX: **M** **F**

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ INSURANCE CO. PHONE: (\_\_\_\_) \_\_\_\_\_

MEMBER / ID #: \_\_\_\_\_ GROUP/POLICY #: \_\_\_\_\_

At the time of your visit with us you MUST present your Ins.card –Today +valid ID to allow yourself for submission for your benefits. Mgmt

**I UNDERSTAND THAT MY INSURANCE IS NOT A GUARANTEE OF PAYMENT; I UNDERSTAND THAT PAYMENT FOR SERVICES TO IMPROVE MY DENTAL CONDITION IS REQUESTED ON THE DAY OF MY VISIT.**

**PATIENTS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT SIGNATURE (if minor):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ALL FUTURE CHANGES IN THE ABOVE INFORMATION.**

*WELCOME TO Heavenly Smiles Dental*