Jonathan J. Smith, D.D.S.

I. PATIENT INFORMATION

Today's Date_____

Patient Name_____
Last First Middle Initial

Home Address_____ City_____ State/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____
Please circle which number is best daytime contact for you

E-mail address_____ Birthdate_____ Soc.Sec #_____

Occupation_____ Employer_____ Marital Status_____

Spouse's Name_____ Spouse's Occupation_____

Spouse's Employer_____ Spouse's Work Phone_____

Who should we contact in case of emergency?_____Phone Number_____

Who may we thank for referring you to our office?_____

II. RESPONSIBLE PARTY INFORMATION (If different than above)

Name _____ Relationship to patient _____
Last First Middle

Residence: Street _____ City _____ State/Zip _____

Mailing Address _____ City _____ State/Zip _____
If different than residence

Home Phone _____ Work Phone _____ Birthdate _____

III. INSURANCE INFORMATION

Does patient have dental insurance coverage? _____	Does patient have dental insurance coverage? _____
PRIMARY INSURANCE	**SECONDARY COVERAGE**
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Birthdate _____	Subscriber's Birthdate _____
Subscriber's Soc. Sec. # _____	Subscriber's Soc. Sec. # _____
Subscriber's Employer _____	Subscriber's Employer _____
Insurance Company _____	Insurance Company _____
Insurance Co. Address _____	Insurance Co. Address _____
_____	_____
Group # _____Local # _____	Group # _____Local # _____

ASSIGNMENT & RELEASE: I authorize the dentist or insurance company to release any information required for payment or review of insurance claims. I hereby authorize my insurance benefits to be paid directly to Jonathan J. Smith, D.D.S. and I am financially responsible for any balance due, regardless of the amount my insurance chooses to pay, or in the event of nonpayment by my insurance company.

Signature (Parent if minor) _____ **Date** _____