

Welcome to Smile Tucson!

If you have any questions, or if we can help you in any way, please feel free to ask!

PATIENT INFORMATION (Confidential)

Name _____ SSN _____
(Please Print) Last Name First MI

Date of Birth _____ Sex: Male Female (If child, parent/guardian name) _____

Address _____ PO Box _____
(Please Print)
City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____ Ok to call work? Y N

Primary Contact #? Home Cell Work Best time to Call? _____ E-mail Address _____

Employer _____ Occupation _____ How long there? _____

Employer Address _____ City _____ State _____ Zip _____

Spouse Name - or -

Parent /Guardian Name _____ SSN _____
(Please Print) Last Name First MI

Date of Birth _____ Home # _____ Cell # _____ Work # _____

Address _____ City _____ State _____ Zip _____
(If Different than above)

If patient is a student: Name of school/college _____ City & State _____
 Full time Part time

*How did you hear about us? Monument Sign Office sign Website Ads/Newspaper Other _____

Friend / Family Name _____

Insurance Information

Primary Insurance:

Name of Insured (Sponsor) _____ DOB _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Company _____ Contact Phone # _____

Insured SSN _____ or Subscriber ID # (if different from SSN) _____

Group # _____ or Local / Union Name # _____

Additional / ***Secondary Insurance:

Name of Insured (Sponsor) _____ DOB _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Company _____ Contact Phone # _____

Insured SSN _____ or Subscriber ID # (if different from SSN) _____

Group # _____ or Local / Union Name # _____

***Note that all secondary benefits will go directly to you, the patient.

Emergency contact:

Someone we may contact, not living with you: _____ Phone # _____

Authorization

I authorize my insurance to make insurance payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records as deemed necessary to third party payers, other health professionals or other healthcare operation. I authorize use of this signature for all insurance submissions.

I understand I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

*Signature _____ Date _____
Patient / Parent / Legal Guardian

***Office Use: HIPPA form signed Y _____