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.

<u>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</u>. 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** ________

ST Form 1001