All Smiles
DENTAL CARE

PATIENT INFORMATION FORM

Name: _____
Last First MI

Street: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Employer: _____ Work phone: _____

E-mail address (optional): _____

Social Security #: _____ Date of Birth: _____ Male / Female (CIRCLE ONE)

Marital Status (CHECK ONE): ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Child

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about ALL SMILES DENTAL CARE? _____

INSURANCE INFORMATION: Please present your insurance card so that it may be photocopied

Do you have dental insurance? (circle) Yes/No Do you have secondary dental insurance? (circle) Yes/No

Primary Insured	**Secondary Insured**
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Date of Birth:	Date of Birth:
Relationship To Subscriber: Self Spouse Child Other	Relationship To Subscriber: Self Spouse Child Other
Employer Name:	Employer Name:
Employer Phone:	Employer Phone:
Insurance Company:	Insurance Company:
Insurance Group #:	Insurance Group #:
Insurance Phone #:	Insurance Phone#:

RELEASE OF INFORMATION TO INSURERS AND ASSIGNMENT OF BENEFITS
(Must be signed by ALL patients wishing to use insurance benefits)

To the extent permitted by law, I consent to All Smile Dental Care's use and disclosure of my protected health information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for evaluating and administering claims for benefits. I understand that it is my responsibility to know what the terms of my insurance are, and understand I am responsible for payment of services rendered and for any co-payments/deductibles that my insurance does not cover, regardless of whether the original estimate included an expected benefit. I further authorize payment directly to All Smiles Dental Care of the dental benefits otherwise payable to me. If the insurance plan will not pay benefits directly to All Smiles Dental Care, you will bear full financial responsibility for your treatment plan, according to our payment policy.

Patient/Legal Guardian's Signature _____ **Date** _____