PIKE DISTRICT
SMILES

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Preferred Name: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Sex: ○ Male ○ Female

Birth Date: _____ Age: _____ Soc. Sec: _____

Email: _____ ○ I would like to receive correspondence via email

Employer: _____ Occupation: _____

Spouse: _____

Children's Names: _____

Is there anyone we may thank for referring you to our offices? _____

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____ Ins. Phone#: _____

Ins. Co. Address: _____

Group #: _____ ID #: _____

Payment Options

To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now expect payment in full on your first visit. Subsequent visit balances not covered by your insurance can be paid using the following options:

Please (✓) below the option(s) most convenient for you to pay on your account balance.

- ○ Cash
- ○ Check
- ○ Visa, MC, Amex, or Discover
- ○ Easy monthly payment program (see insurance coordinator for application)

_____ _____

Signature of Responsible Party Date