smiles
ON STATE STREET

Section I: **Patient Information** **Date_____**

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ A.M. P.M. on my _ Home phone _ Work phone _ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: Minor Single Married Widowed Separated Divorced
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III **Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____