



**PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER NAME AND ADDRESS \_\_\_\_\_

<u>BIRTHDATE</u> ____ / ____ / ____	<u>SS#</u> ____ - ____ - ____ <u>DL#</u> ____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <u>MARITAL STATUS</u> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> UNDER 18
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PHONE #S HOME ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL ( ) \_\_\_\_\_ - \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY/GUARANTOR OF PAYMENT (IF OTHER THAN PATIENT)**

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER NAME AND ADDRESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL# \_\_\_\_\_

PHONE#S HOME ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL ( ) \_\_\_\_\_ - \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

PRIMARY INSURANCE

SUBSCRIBER'S FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 SUBSCRIBER'S STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ GROUP# \_\_\_\_\_  
 INSURANCE PLAN NAME/ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
 SUBSCRIBER'S EMPLOYER NAME/ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

SECONDARY INSURANCE (IF APPLICABLE)

SUBSCRIBER'S FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 SUBSCRIBER'S STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ GROUP# \_\_\_\_\_  
 INSURANCE PLAN NAME/ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
 SUBSCRIBER'S EMPLOYER NAME/ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**CONSENT FOR SERVICES**

I understand that I am responsible for payment of all services rendered on my behalf or on behalf of my dependants. I understand that if I have dental insurance, my carrier may pay less than the actual bill for services and any outstanding charges are my responsibility. All co-pays/ deductibles are due in full at the time services are rendered. All emergency services must be paid for in cash at the time services are rendered. We accept cash, check, Visa and MasterCard. We cannot extend the courtesy of charge accounts. There is a \$35 charge for missed/cancelled appointments without 48 hours notice. I understand that there is no expressed, written or implied guarantee associated with any dental services I receive at Smiles by Design, PLC. I grant my permission to Smiles by Design, PLC to telephone me at home or at my work to discuss matters related to this form. I authorize Smiles by Design, PLC to release any information regarding my dental care herein to third party payors and/or health practitioners. I authorize my insurance company to pay directly to Dr. Boone benefits otherwise payable to me.

**I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Signature of responsible party/guarantor \_\_\_\_\_ Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_