WINTER PARK LIFE SMILES

PATIENT INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F DOB _____M _____D _____Y Marital Status ☐S ☐M ☐W ☐D Weight _____lbs. Height _____

Employer's Name _____ Occupation _____

Employer's Address _____ Business Phone _____

SSN _____ Which doctor do you see? _____

PARTY RESPONSIBLE FOR ACCOUNT

Name _____ Home Phone _____

Address _____

Relationship to Patient _____ Business Phone _____

DENTAL INSURANCE

Insured Party _____ SSN of Insured _____

Place of Employment _____ DOB of Insured _____M _____D _____Y

Carrier _____ Policy No. _____

Send Claims To _____

OTHER

Previous Dentist's Name & Address _____

Physician's Name & Address _____

In Case of Emergency Notify Name _____

Relationship to Patient _____ Phone(s) _____

Whom may we thank for referring you to us? _____

X _____

I authorize the release of any information necessary to process my insurance claim.

X _____

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me.
A copy of this signature is as valid as the original.