Jordan Elbridge Family Smiles

PATIENT INFORMATION

PATIENT NAME MALE FEMALE BIRTHDATE SS#

STREET ADDRESS CITY STATE ZIP

HOME PHONE # CELL PHONE # EMAIL ADDRESS

SPOUSE'S NAME SPOUSE'S DOB SPOUSE'S SS# SPOUSE'S EMPLOYER

PATIENT'S EMPLOYER PATIENT'S WORK PHONE #

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

INSURANCE INFORMATION

INSURED'S NAME INSURED'S DOB RELATIONSHIP TO PATIENT

INSURED'S SS# INSURED'S ID# INSURANCE CO. NAME GROUP #

INSURED'S EMPLOYER EMPLOYER ADDRESS

DO YOU HAVE SECONDARY DENTAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING.

INSURED'S NAME INSURED'S DOB RELATIONSHIP TO PATIENT

INSURED'S SS# INSURED'S ID# INSURANCE CO. NAME GROUP #

INSURED'S EMPLOYER EMPLOYER ADDRESS

PAYMENT POLICY

- Payment is expected at the time services are rendered. Unless other arrangements have been made. (As a service we will submit insurance claims and pretreatment estimates.)
- Dental insurance is intended to offset only a percentage of dental treatment. This insurance is a contract between you and your insurance carrier. The cost of services provided for you are your sole financial obligation.

I have read the above payment policy and hereby authorize the doctor to perform any treatment that may be indicated. I also understand that prior to treatment a full explanation will be given by the doctor or his staff. I agree to pay for all services rendered by this office.

_____ _____

Signature of responsible party Date

May we: (please initial)

_____ Leave any messages on home phone or cell phone.

_____ Speak to spouse/parent regarding any treatment or fees associated with treatment.

Signature _____ Date: _____