Forever Smiles, P.A.

PATIENT INFORMATION

(Please Print)

Date: _____

Patient's Name (Mr./Mrs./Miss): _____
Last First MI

Address: _____
Street Apt. #/Suite City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date _____ SSN: _____ Marital Status: _____

E-mail address: _____ Sex: Male / Female

Employer: _____ Occupation: _____

Spouse's Name: _____
Last First MI

Spouse's Birth Date: _____ Spouse's Employer: _____

If patient is a minor, give parent or guardian's name: _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Insurance Company: _____

ID #: _____ Group #: _____

Do You Have Secondary Insurance? Yes / No If yes: _____

Subscriber's Name: _____ Subscriber's SSN: _____

ID #: _____ Group #: _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS PAYABLE TO ME.

_____
(Signed patient or parent, if minor)

FINANCIAL POLICY

We accept Cash, Visa, Master Card, Discover, American Express, and Care Credit as payment for all services.
We ask our patients for payment at the time of service.
WE DO NOT ACCEPT CHECKS. We apologize for any inconvenience.
If you need to cancel or reschedule an appointment, we ask for at least 24 HOURS NOTICE.
We reserve the right to charge a $25 fee for appointments cancelled or broken without 24 hours notice.

_____
(Signed patient or parent, if minor)