j Dailey, DDS
SMILE DAILEY
GENERAL & COSMETIC DENTISTRY

Patient Information

Name _____
Last First MI

Home Address _____
Street/PO Box/Apt #

_____
City State Zip

Birth Date _____ Male Female
SS # _____ Single Married
Home # _____ Cell # _____
Work # _____ Ext. _____

How would you like your appointments confirmed? (circle)
Email Text Phone Call

Email _____

May we contact you at work? YES NO

Name and number of emergency contact:

_____

_____

Referral

Whom may we thank for recommending us to you?

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You may refuse to sign this acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name _____
Employer _____
Program/Policy # or Group ID # _____
Employee Name _____
Employee Date of Birth _____
Employee SS # _____

Secondary Dental Insurance

Insurance Co. Name _____
Employer _____
Program/Policy # or Group ID # _____
Employee Name _____
Employee Date of Birth _____
Employee SS # _____

I authorize Smile Dailey Dental to release any information needed to process my insurance claims. Smile Dailey Dental will file my insurance as a courtesy, however, I understand that I am ultimately responsible for payment of all services rendered.

I assign benefits payable, for the services provided, to Smile Dailey Dental or the provider.

Signature _____

Date _____

Person Responsible for Account (if other than Patient):

Name _____
Last First MI

Address _____
Street/PO Box/Apt #

_____
City State Zip

Home # _____ Work # _____

SS # _____ Employer _____