PFLUGERVILLE SMILES DENTISTRY
Creating Miles of Smile. Your Smile is Our Passion.

Patient Information

PATIENT

Name: _____
(first) **(last)**

Address: _____ **Apt#**_____

City: _____ **Zip:** _____

How long at this address?_____

Phone: ( ) _____

Cell/Pager: ( )_____

E-mail: _____

DL#: _____

Age: _____

RESPONSIBLE PARTY

Name: _____
(first) **(last)**

Address: _____ **Apt#** _____

City: _____ **Zip:** _____

How long at this address?_____

Phone: ( ) _____

Relationship to Patient: _____

Age: _____

EMPLOYMENT

Occupation: _____

Employer: _____

How long? _____

City:_____

PERSON TO CONTACT FOR EMERGENCY

Name: _____

Phone: ( ) _____

Physician Name:_____

Phone: ( ) _____

GETTING TO KNOW YOU

How did you hear about us? (Circle One)

Friend
Newspaper
Internet Website
Flyer/Promotion
Office Sign
Yellow Pages
Insurance Plan
Drive By

Other:

INSURANCE / DENTAL PLAN

Insurance PPO HMO Cash(Circle One)

Primary Insurance

Plan Name: _____

Address:_____

City, Zip:_____

Insurance Phone #:_____

Employer:_____

Union/Local:_____

Union Group #:_____ **Union Plan #:**_____

Insured Name: _____
(first) **(last)**

Insured SSN:_____ **Birthdate:**_____

Secondary Insurance

Plan Name: _____

Address:_____

City, Zip:_____

Insurance Phone #:_____

Employer:_____

Union/Local:_____

Union Group #:_____ **Union Plan #:**_____

Insured Name: _____
(first) **(last)**

Insured SSN:_____ **Birthdate:**_____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services in our office. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

_____

Signature of Responsible Party or Patient **Date**