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Natural Smiles by design PC

SECTION A — Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent

Chart #_____
FOR OFFICE USE ONLY

Patient Name:_____ _____ _____ Title:_____ Gender:_____ Family Status:_____
Last First MI Mr/Ms/Mrs/etc M/F Married/Single/Other

Birth Date:_____ Email Address:_____ Phone:_____ _____ _____
Home Work Mobile

Adress:_____ _____ _____ _____
Street City State Zip

Preferred appointment time:_____ Who can we thank for your referral:_____
Day AM /PM

SECTION B — Spouse or Responsible Party Information

The following information is for: ❍ the patient's spouse ❍ the person responsible for payment

Patient Name:_____ _____ _____ Title:_____ Gender:_____ Family Status:_____
Last First MI Mr/Ms/Mrs/etc M/F Married/Single/Other

Birth Date:_____ Email Address:_____ Phone:_____ _____ _____
Home Work Mobile

Adress:_____ _____ _____ _____
Street City State Zip

SECTION C — Employment Information

The following information is for: ❍ the patient's spouse ❍ the person responsible for payment

Employer Name:_____ Phone:_____ Years with company:_____

Adress:_____ _____ _____ _____
Street City State Zip

Primary Dental Insurance Information

Name of Insured: ❍ Same as section A ❍ Same as section B
Other_____

Group #_____

Insured's Address: ❍ Same as section A ❍ Same as section B
Other_____

Insured's Employer Name: ❍ Same as section C
Other_____

Employer Address: ❍ Same as section C
Other_____

Patient's relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insurance Plan Name:_____

Secondary Dental Insurance Information

Name of Insured: ❍ Same as section A ❍ Same as section B
Other_____

Group #_____

Insured's Address: ❍ Same as section A ❍ Same as section B
Other_____

Insured's Employer Name: ❍ Same as section C
Other_____

Employer Address: ❍ Same as section C
Other_____

Patient's relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insurance Plan Name:_____