Michael C. Smuin DDS

PATIENT INFORMATION Date_____

First Name_____ M.I._____ Last Name_____

Address_____ City_____ State_____Zip_____

Home Phone_____ Cell_____ Work_____

Birthdate_____ SSN_____ Sex M F Martial Status M S W D

Employer_____Phone_____

Emergency Contact Person_____Phone_____

RESPONSIBLE PARTY

Name_____ Relationship to Patient_____

Billing Address_____City_____ State_____Zip_____

Phone Number_____Birthdate_____ SSN_____

Insurance Coverage (Y/N)_____Insurance Company_____

Employer Name_____Phone_____

INSURANCE INFORMATION

Primary Insurance

Insured's Name_____SSN_____

Patient's Relationship to Insured: Self_____Spouse_____Child_____Other_____

Employer_____Phone Number_____

Insurance Company_____Group Number_____

Claim Address_____City_____State_____Zip_____

Secondary Insurance

Insured's Name_____SSN_____

Patient's Relationship to Insured: Self_____Spouse_____Child_____Other_____

Employer_____Phone Number_____

Insurance Company_____Group Number_____

Claim Address_____City_____State_____Zip_____