Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

Smiles South Center 15425 53rd Avenue S, Tukwila, WA 98188 (206) 575-9150

PATIENT INFORMATION

Name _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Cell # (____)_____

DOB: ____/_____/_____SSN# _____ E-mail _____@_____

Spouseôs Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ____/_____/_____

SSN# _____

Relationship: _____

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?

_____ _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriberôs Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriberôs SSN# _____

Insurance Company _____ Policy # _____ Group #_____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

Date _____ Account #_____

CONFIDENTIAL