Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Driver's License # _____ Email _____

Phone (Home): _____ (Work): _____ *(Cell):* _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

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

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Consent for Services

Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-pay and deductible that my insurance does not cover. I authorize payment directly to Radiant Smiles LLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company,

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Office policy for Radiant Smiles LLC includes the following:

-We call one to two business days prior to confirm your scheduled appointment. This is a courtesy, you are ultimately responsible to keep your appointment.

-We reserve the right to charge your account $50.00 if you miss an appointment or cancel without 24 hours notice.

-We will gladly submit your insurance claims, as the insured you are responsible to know your plan policy including your maximum benefit allowed, procedures, and percentage covered.

-Anything that is not covered by your insurance company is your financial responsibility.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Notice of Privacy Practices

I have reviewed the Notice for Health Information and Privacy Practice (HIPPA) for *Radiant Smiles LLC*. I am aware of how this Information may be used and disclosed, and how I can obtain access to this information. I have been offered a copy of the HIPPA policy for *Radiant Smiles LLC* and I am aware that I may request a copy of this policy at any time.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian