Welcome to Sweet Tooth Dental Center

Date_____

Patient Information

Name_____ Social Security #_____
Birthdate_____ Age_____ E-mail_____
Gender: Male ___ Female___ Married___ Single___ Child___ Widowed___ Separated___ Divorced___ Partnered___
Address_____City_____State_____ Zip_____
Home Phone(____)_____ Cell Phone(____)_____ Work Phone(____)_____
Patient Employer/School_____ Occupation_____
Employer/School Address_____ Employer/School Phone(____)_____
Whom may we thank for referring you?_____
How did you hear about our office? walking by letter postcard Google Yelp Facebook
In Case of emergency who should we notify_____ Relationship_____
Phone(____)_____

Insurance Information

Primary

Person responsible for account_____
Relation to patient_____ Birthdate _____ ID#/Soc. Sec.#_____
Address (if different from patient's)_____ Phone(____)_____
City_____ State_____ Zip_____
Employed By_____ Occupation_____
Business Address_____Work Phone(____)_____
Insurance Company_____
Insurance Phone(____)_____Group #_____ Subscriber #_____

Secondary

Person responsible for account_____
Relation to patient_____ Birthdate _____ ID#/Soc. Sec.#_____
Address (if different from patient's)_____ Phone(____)_____
City_____ State_____ Zip_____
Employed By_____ Occupation_____
Business Address_____Work Phone(____)_____
Insurance Company_____
Insurance Phone(____)_____Group #_____ Subscriber #_____

I certify that I, and/or my dependent(s), have insurance with _____ and assign directly to Dr. Sharon Shamoiel all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature and any of my other information on all insurance submissions. I understand that payment is due in full at the time of treatment.

_____ _____ _____ _____
Print Name Signature Relationship to Patient Date