

DENTISTRY WITH A SMILE, LLC.

PERSONAL HISTORY

First Name	Last Name	If a Minor, Parent's Name			Date of Birth
Street Address	City	State	Zip Code	Home Phone	Cell Phone / Work Phone
				()	() ()
Social Security #:		Marital Status		How would you like to be contacted (i.e. appointment confirmation, billing, insurance verification)	
Email Address :				Home <input type="checkbox"/>	Work <input type="checkbox"/> Cell <input type="checkbox"/>
Employer (Include Address):			Occupation	Can we call you at work?	
				YES NO	
In Case of Emergency, Notify:	Phone:	How will Acct be Paid?		Name of Dental Insurance Co.	
Policy #	Name of Secondary Insurance Co. (if any)			Social Security #	
Name of Spouse	Spouse Employed By			Occupation	
Referred By:					

PH
DH

ADDRESS / JOB CHANGES (if applicable)					
Home Address:		City	State	Zip Code	Home Phone / Cell Phone
Employer / Address:			Work Phone :	Occupation:	
Home Address:		City	State	Zip Code	Home Phone / Cell Phone
Employer / Address:			Work Phone :	Occupation:	
INSURANCE CHANGES					
Name of Dental Insurance Co.		GROUP #:		Additional Information:	
		SUBSCRIBER ID:			
Name of Dental Insurance Co.		GROUP #:		Additional Information:	
		SUBSCRIBER ID:			