Radiant Smiles Family Dental, PLLC

We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? _____

Patient Information

Patient's Name Last _____ First _____ MI _____

Address Street _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Email Address _____ Social Security # _____-____-_____

Birthdate _____/_____/_____ If patient is a minor, give parent's/guardian's name_____

Emergency contact _____ Phone number (_____) _____

Responsible Party Information

Name Last _____ First _____ MI _____ Marital Status _____

Residence Street _____ City _____ State _____ Zip _____

Mailing address Street _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Social Security # _____-____-_____

Birthdate _____/_____/_____ Relationship to patient _____

Employer _____ Occupation _____

Employer Address _____

Insurance Company _____ Group # _____

Insurance Company Address _____ Phone (_____) _____

Secondary Insurance Information

If you have dual coverage, please fill out the following:

Spouse's Name _____ Work Phone (_____) _____

Social Security # _____-____-_____ Birthdate _____/_____/_____ Relationship to patient _____

Employer _____ Occupation _____

Employer Address _____

Insurance Company _____ Group # _____

Insurance Company Address _____ Phone (_____) _____

Payment Responsibility

*For our patients without dental insurance.....*I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

*For our patients with dental insurance.....*I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of all dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office. If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all collection costs.

I understand that it is my responsibility to advise your office of any changes in the information on this form.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____