*Welcome!*
*Thank you for selecting Summit Smile Center. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any question or need assistance, please ask us and we will be happy to help.*

**Today's Date:**

## Patient Information

| Mr. Mrs. Ms. Dr. (please circle) | Last Name | First Name | Middle Name/Initial |
|---|---|---|---|

| Name You Prefer | Date of Birth | Age | MALE FEMALE Sex (please circle) |
|---|---|---|---|

| Home Phone ( ) | Cell Phone ( ) | Email Address |
|---|---|---|

| Social Security # | Minor Single Married Divorced Separated Widowed Status (please circle) |
|---|---|

| Mailing Address | City | State | Zip |
|---|---|---|---|
| Physical Address | City | State | Zip |

| Occupation/Job Title | Employer/School | Hobbies/Special Interests |
|---|---|---|

**Whom may we thank for referring you?**

## Insurance Information

| Name of Insured | Relationship to Patient |
|---|---|

| Date of Birth | Social Security # | Insurance Company Name |
|---|---|---|

| Insurance Phone Number | ID # | Group # |
|---|---|---|

| Claims Mailing Address | City | State | Zip |
|---|---|---|---|

### 24 Hour Cancelation Policy

I understand that any appointment I schedule is reserved exclusively for me. Any changes to my appointment affects Summit Smile Center's schedule as well as many other patients, I also understand that cancellations made with less than 24 hours notice will result in a missed appointment fee of $60.00.

**Patient (or Parent) Signature: ____________________________________________Date: _____________________**

### Financial Policy

I authorize Summit Smile Center to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payer and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand I am required to pay at the time of treatment for any portion not expected to be paid by insurance. If my dental insurance carrier pays less than expected, I understand any remaining balance is my responsibility and I agree to pay for all services rendered on my behalf or my dependent(s) behalf. In addition to services rendered, I agree to pay for any collection costs and 1.5% service fee. If Summit Smile Center seeks enforcement of payment through the services of a collection agency I shall be responsible for any incidental expenses, including collection cost/attorney fees.

**Patient (or Parent) Signature: ____________________________________________Date: _____________________**