SMILE KEEPERS
NEW PATIENT FORM

TODAY'S DATE: _____

PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____AGE: _____
PREFERRED NAME: _____ MALE _____ FEMALE_____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
SOCIAL SECURTIY #_____

ONLY FOR PATIENT'S UNDER 18 years

PARENT/GUARDIAN FULL NAME: _____DATE OF BIRTH: _____
PERSON RESPONSIBLE FOR MAKING DENTAL APPOINTMENTS AND FINANCIAL ARRANGEMENTS:
_____

PLEASE LIST IN ORDER THE BEST NUMBER TO REACH YOU FOR A DENTAL APPOINTMENT:
CELL PHONE: _____CAN YOU RECEIVE TEXT MESSAGES? YES NO
WORK PHONE: _____
HOME PHONE: _____
EMAIL: _____

HOW DID YOU HEAR ABOUT US: Google: __Facebook: __Location/passing by: __Flyer: ____Insurance
Referred by: _____Other Sources: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME OF THE EMERGENCY CONTACT: _____ RELATION: _____
ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____
CELL PHONE: _____WORK PHONE: _____HOME PHONE: _____

PERSON WITH WHOM WE CAN SHARE THE DENTAL HEALTH INFORMATION:

NAME OF THE PERSON: _____ DATE OF BIRTH: _____
CELL PHONE: _____WORK PHONE: _____HOME PHONE: _____

AUTHORIZATION

I authorize **Smile Keepers** to release any and all medical or dental information for evaluation, treatment and any anticipated care. I understand that I am responsible for any charges (including collection fees). I understand that the estimated patient portion is due at the time that services are rendered unless other arrangements have been made for payment. I also understand that any treatment estimate that is given to me is done in good faith, and I understand that my insurance may not pay the amounts estimated by **Smile Keepers**. I understand that I am responsible for knowledge of my insurance program and the limitations of it. I have read this authorization and understand its contents.

Signature: _____Date: _____Relationship to the patient: _____