SMILE INNOVATIONS
DENTISTRY

NEW PATIENT FORM

Pharmacy and Insurance Information Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Primary Dental Insurance Is subscriber the same as patient? Yes No

Subscriber Information: First Name: _____ Middle Initial: ____ Last Name: _____

Subscriber ID/Policy Number: _____ Subscriber SSN: _____

Employer Name: _____

Insurance Company: _____ Ins Phone Number: _____

Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

Secondary Dental Insurance Is subscriber the same as patient? Yes No

Subscriber Information: First Name: _____ Middle Initial: ____ Last Name: _____

Subscriber ID/Policy Number: _____ Subscriber SSN: _____

Employer Name: _____

Insurance Company: _____ Ins Phone Number: _____

Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

I consent to be a patient and agree to radiographic and clinical examinations. During the course of treatment, I may undergo procedures in all phases od dentistry including periodontics, oral surgery, endodontics, fixed and removable prosthodontics, implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I agree to update this information periodically, or as needed.

I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand my treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I may be unsure about.

Signature _____ Date: _____