

Get Acquainted

About Your Smile, P.C.

Date _____

SECTION 1

Patient Name _____	Birthdate _____
<small>Last First Initial</small>	<small>Mo. Day Yr.</small>
Name of Spouse _____	
Or if Child, Name of Parent(s) _____	
<small>Last First Initial</small>	<small>Last First Initial</small>
Mailing Address _____	
City/State/Zip _____	Phone (H) _____ (W) _____
Patient/Parent Work For: _____	Spouse/Other Parent Work For: _____
Who is responsible for payment not covered by insurance? _____	
How did you find out about our office? Sign <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Friend <input type="checkbox"/> Ad <input type="checkbox"/> Patient <input type="checkbox"/>	
E-mail Address: _____	
Patient Social Security Number: _____ - _____ - _____	

SECTION 2

Dental Insurance – 1st Coverage <i>(If you have Keystone Mercy, Health Partners or AmeriChoice, skip to Section 3)</i>	
Employer _____	Job Title _____ #Yrs. at this job _____ Name of Ins. Co. _____
Employee Name _____	Employee Date of Birth _____
	<small>Mo. Day Yr.</small>
Address of insurance Company: _____	
Telephone # of Ins. Company _____	Insured Social Security # _____ - _____ - _____
Program or Policy # _____	Union or Group # _____
FOR STAFF USE ONLY UCR <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/>	
Annual Max \$ _____	Deductible \$ _____ P _____ OP _____ CNB _____ Perio _____ Ortho _____
Dental Insurance – 2nd Coverage	
Employer _____	Job Title _____ #Yrs. at this job _____ Name of Ins. Co. _____
Employee Name _____	Employee Date of Birth _____
	<small>Mo. Day Yr.</small>
Address of insurance Company: _____	
Telephone # of Ins. Company _____	Insured Social Security # _____ - _____ - _____
Program or Policy # _____	Union or Group # _____
FOR STAFF USE ONLY UCR <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/>	
Annual Max \$ _____	Deductible \$ _____ P _____ OP _____ CNB _____ Perio _____ Ortho _____

SECTION 3

<i>I certify that I have provided ALL insurance information. Federal and state law require that About Your Smile, P.C. collect from insurance carriers in a specific order.</i>	
<i>I Certify that I will notify About Your Smile, P.C. of any updates of this information.</i>	
Patient or Guardian <input checked="" type="checkbox"/> _____	Date _____
<small>Signature</small>	<small>Mo. Day Yr.</small>

