<table>
<tr><th colspan="6">PLEASE PRINT AND COMPLETE ALL ENTRIES</th></tr>
<tr><td>Patient Name (Last, First, MI)</td><td>Rel'p to Insured</td><td>Date of Birth</td><td>Age</td><td>Marital Status</td><td>Today's Date</td></tr>
<tr><td colspan="2">Complete Address</td><td colspan="2">Home Phone</td><td colspan="2">Work Phone</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">Cell Phone</td><td colspan="2">Email</td></tr>
<tr><td colspan="2">Insured Employer Name</td><td colspan="2">Occupation</td><td colspan="2">Social Security No.</td></tr>
<tr><td colspan="6">Employer Address</td></tr>
<tr><td>Spouse's Name (Last, first, MI)</td><td>Date of Birth</td><td colspan="2">Social Security No.</td><td colspan="2">Spouse's Work Phone</td></tr>
<tr><td colspan="2">Spouse's Employer Name & Address</td><td colspan="2">Occupation</td><td colspan="2"></td></tr>
<tr><td>Nearest relative not living with you</td><td colspan="3">Address (Street, City, State, Zip)</td><td colspan="2">Home Phone
(   )   -</td></tr>
<tr><td>Emergency contact</td><td colspan="3">Relationship</td><td colspan="2">Phone
(   )   -</td></tr>
<tr><td colspan="6">Who is financially responsible for this bill?</td></tr>
<tr><td colspan="6">How will the bill be paid today?</td></tr>
<tr><td colspan="6">Who referred you to our practice? (Referring patients get a $25 credit toward treatment, and we love patient referrals!)</td></tr>
<tr><td colspan="6">Would you like whiter teeth? Would you like straighter teeth? Are you missing any teeth that you would like to replace?</td></tr>
<tr><td colspan="6">Would you be interested in a payment or no-interest finance plan? Would you be interested in a mechanical toothbrush?</td></tr>
<tr><td colspan="6">What dental concerns would you like to discuss with the staff today?</td></tr>
<tr><th colspan="6">INSURANCE INFORMATION</th></tr>
<tr><td>Primary Insurance Co. Name (DENTAL)</td><td colspan="3">Address (Street, State, City, Zip)</td><td colspan="2">Phone
(   )   -</td></tr>
<tr><td>Name of Insured</td><td>Relationship</td><td colspan="2">I.D. No.</td><td colspan="2">Group No.</td></tr>
<tr><td>Secondary Insurance Name(DENTAL)</td><td colspan="3">Complete Address</td><td colspan="2">Phone
(   )   -</td></tr>
<tr><td>Name of Insured</td><td>Relationship</td><td colspan="2">I.D. No.</td><td colspan="2">Group No.</td></tr>
</table>

I authorize the dentist 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 payers and/or other health practioners.

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

x____

Signature of patient or parent if minor   Date

Smiles Ahead Family Dentistry