We warmly welcome you!

The better we communicate, the better we can care for you.

1. ABOUT YOU

PATIENT INFORMATION

Full Name ______________________________ Preferred Name ______________________________

Address ______________________________ City ______________ State_______ Zip _________

Phone # (______) ________________ Alt Phone # (______) ________________ Sex ☐ Male ☐ Female

Birthdate ________________ Email ______________________________

Name of Employer/School ______________________________

Sports or other activities ______________________________

2. ACCOUNT RESPONSIBILITY

☐ Self ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other

First Name ______________________________ Last Name ______________________________

Address ______________________________ City ______________ State_______ Zip _________

Phone # (______) ________________ Alt Phone # (______) ________________

Birthdate ________________ SS# ________________

Email ______________________________

REFERRED BY ______________________________

EMERGENCY CONTACT

Contact Name ______________________________ Phone # ______________________________

Relationship ______________________________

3. DENTAL INSURANCE

PRIMARY INSURANCE

Name of Policy Holder ______________________ Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder SS# ______________________ Policy Holder Birthdate ______________________

Insurance Company Name ______________________

Insurance Company Phone # (______) ______________________ Employer ______________________

SECONDARY INSURANCE

Name of Policy Holder ______________________ Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder SS# ______________________ Policy Holder Birthdate ______________________

Insurance Company Name ______________________

Insurance Company Phone # (______) ______________________ Employer ______________________

4. DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature ______________________ Date ______________________

5. PRIVACY PRACTICES

I acknowledge the receipt of NOTICE OF PRIVACY PRACTICES and understand that Smile Grand Haven and its affiliates abides by the HIPAA Law and will protect the privacy of my personal information.

Printed Name ______________________

Signature ______________________ Date ______________________

**** You may refuse to sign this acknowledgement ****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited us from obtaining acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other ______________________