1012 State Route 521
Delaware, OH 43015
Tel: 740-417-9565
Fax: 740-417-9571
www.smilecenterohio.com

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION

Full Legal Name____ **Gender [ ] M [ ] F**

(Preferred Name)

Birthdate __________________________ **SS#** _______________ **Married [ ] Y [ ] N**

Home Phone: _________________ **Work Phone:** _________________ **Wireless Phone:** _______________

Email Address:____

Home Address: ______________________________**City**_________________ **State** ________ **Zip** ______

Driver's License Number: ____________________ **State Issued:** _____ **Exp. Date** _____________________

Employer Name: ________________________________ **Employer Phone** __________________________

Preferred Contact method for confirmations [ ]HmPhone [ ]WkPhone [ ]WirelessPh [ ]Email

Whom may we thank for referring you to us?

____

(If someone referred you, please write down their name so we can thank them)

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PRIMARY DENTAL INSURANCE

Your relationship to subscriber: [ ]Self [ ] Spouse [ ]Child

Name of Insured________________________________ **Relationship to Patient:** ______________________

Date of Birth______________________ **Social Security # of Insured:**_________________________

Insurance Company ___________________________________ **Phone #** ___________________________

Employer _________________________ **ID #**_______________________ **Group #** _________________

Student status if dependent over age 19 (for insurance) [ ]Nonstudent [ ]Fulltime [ ]Parttime
Name of School ____

Please present insurance card to receptionist

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SECONDARY DENTAL INSURANCE OR MEDICAL/HEALTH INSURANCE

Your relationship to subscriber: [ ]Self [ ] Spouse [ ]Child

Name of Insured________________________________ **Relationship to Patient:** ______________________

Date of Birth______________________ **Social Security # of Insured:**_________________________

Insurance Company ___________________________________ **Phone #** ___________________________

Employer _________________________ **ID #**_______________________ **Group #** _________________

Student status if dependent over age 19 (for insurance) [ ]Nonstudent [ ]Fulltime [ ]Parttime
Name of School ____

Please present insurance card to receptionist