MEQUON SMILE DESIGN

PATIENT INFORMATION

Patient Name	Preferred Name	Birthdate	
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
E-mail	SS# (some insurances require for verification)		

Best Way to contact you ☐ Home ☐ Cell ☐ Work ☐ E-mail

Family Status ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Minor

*****NEW PATIENTS ONLY****

Referred By ☐ Insurance ☐ Google ☐ Another Patient ____________ ☐ Other

EMERGENCY CONTACT

Name	Relationship	Phone
Who is responsible for this account		

EMPLOYER

Patient Employer	Occupation		
Address	City	State	Zip

DENTAL INSURANCE

Dental Insurance ☐ Yes ☐ No *(if yes, please fill out insurance information below)*

Dental Insurance Carrier	ID # or SS#

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________ Responsible Party Signature

____________________ Relationship to patient

____________ Date