



## Patient Information

Date:  How did you hear about our office?

Patient:

Last Name First Name MI Preferred Name

Address

City, State, Zip:

Home Phone:  Work Phone:

Cell/Other Phone:  SSN:  —  —

Sex: Male  Female  Age:  Birthdate:  Marital Status: Single  Married  Other

Employer:  Occupation:

Name of person responsible for account:

If you have insurance and have not yet provided insurance information, please complete this section

Dental Insurance Company:  Group Number:

Policyholder's Name:  Relationship to patient:

Policyholder's Address

Policy holder's Employer:  Policyholder's Work Phone:

Policyholder's SSN:  Policyholder's Birthdate:

Please read and sign below:

Assignment/ Release:

I, the undersigned, assign directly to Dr. Patrick Im/Beautiful Smile Dentistry all benefits, if any, 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 authorized Dr. Patrick Im to release all information necessary to secure payment to benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date:  Signature:

Minor/Child Consent: I, being the parent or guardian of the patient listed above do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Clara Lee, whether or not I am present at the actual appointment when the treatment is rendered.

Date:  Signature of Parent or Guardian: