Broad St Smiles Patient Information Form

Welcome to our office, are very pleased to have you as a new patient at our practice! Please take a moment to fill out our paperwork. We are happy to answer any questions that you may have.

Personal

Name _____
Last First MI (Preferred)

Mailing Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Social Security # (Important for patients with insurance) _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Preferred phone contact method: [ ] Cell [ ] Home [ ] Work
Preferred contact for appointment reminders [ ] Phone [ ] Text [ ] E-mail
Preferred contact for long term (3-6 Mo.) appt. confirmation [ ] E-mail [ ] Mail

Primary Dental Insurance Policy (Must be PPO)

Relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name _____ Subscriber ID # _____
Subscriber Birthdate _____ Subscriber Social Security # _____
Insurance Company _____ Phone _____
***(Delta Dental members please include State)**
Insurance Company Address _____
City _____ State _____ Zip _____
Employer _____ Group Name _____ Group # _____
Effective Date _____ *Please present insurance card at the Front Desk

Dental Insurance Policy 2

Please bring card or other information with you if you have a secondary policy, and present it to the Front Desk

Other Information

How did you hear about us? [ ] Postcard Mailer [ ] New Mover Letter [ ] Newspaper (New Times, etc.)
[ ] Referral (name) _____ [ ] Online (please describe) _____
[ ] Other _____ [ ] Care to Share Card _____
Reason for Visit: