PATIENT INFORMATION FORM

FAMILY ACCOUNT INFORMATION

Please list all individuals that will be seen as patients at Smile Pediatrics

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

PARENT INFORMATION

*Please place primary contact as Guardian I

Guardian I

Name: ______________________ Gender: ❑ M ❑ F

Birth Date: _______/_______/___________

Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Separated ❑ Divorced

Home #: (______)______________Mobile #: (______)___________

Email: ______________________________

Street Address: ______________________________

City: ________________ State:______ Zip:___________

Employer: ______________________________

Work #: (______)_____________ SSN:_______-______-________

Guardian 2

Name: ______________________ Gender: ❑ M ❑ F

Birth Date: _______/_______/___________

Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Separated ❑ Divorced

Home #: (______)______________Mobile #: (______)___________

Email: ______________________________

Street Address: ______________________________

City: ________________ State:______ Zip:___________

Employer: ______________________________

Work #: (______)_____________ SSN:_______-______-________

Who does patient live with? ❑ Guardian 1 & 2 ❑ Guardian 1 ❑ Guardian 2

DENTAL INSURANCE INFORMATION

Primary Coverage

Name of Insured: ______________________________

DOB: ________________ SSN# ______________________

Employer: ______________________________

Insurance Co: ______________________________

Insurance Co. Phone # (______)______________________

Group/Policy #:________________ID #:____________________

Secondary Coverage

Name of Insured: ______________________________

DOB: ________________ SSN# ______________________

Employer: ______________________________

Insurance Co: ______________________________

Insurance Co. Phone # (_____)______________________

Group/Policy #:________________ID #:____________________

EMERGENCY CONTACT OTHER THAN PARENT

Emergency Contact: ______________________Phone #: (____)______________ Relationship:________________

I affirm the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes to address or insurance information.

Parent Signature: ____ Date: __________________

SACRAMENTO
8689 Folsom Boulevard
Sacramento, CA 95826
(916) 661-6541

EL DORADO HILLS
4517 Serrano Parkway #102
El Dorado Hills, CA 95762
(916) 573-3387

PLACERVILLE
4363 Golden Center Drive
Placerville, CA 95667
(530) 748-3186