Smile Connections Family Dental, L.L.C.
250 N Tyler Road
Wichita, Ks 67212
316-722-8148

PATIENT INFORMATION

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Patient Name
Last: ____________________First: _________M:__________
Preferred Name: ____________________________________
□Single □Married □Divorced □Widowed
If Child: Parents name: _______________________________
Address: ____
City:______________________ State: ________ Zip: _______
Date of Birth: _______/_______/_______
Social Security Number: _________-________-________
Sex: □ Male □Female
Preferred Communication:
□Text □Email □Phone __home __cell __work
Home phone___________________ Cell phone ___________
Work phone ___________________Ext._________________
Email ____

RESPONSIBLE PARTY (if other than the patient)

Name: ____
Address: ____
City: _______________________State: ________ Zip: ______
Home Phone:___________________ Cell: ________________
Work Phone: ___________________ Ext. ________________
Social Security Number: ____-____-_____D.O.B ___/___/___
Relationship to patient: ______________________________
Employer: _________________________ How long: ________
Occupation: ____

EMERGENCY CONTACT/CARE GIVER
(Who does not live in your household)

Name: ____
Relationship: ______________________________________
Home Phone: _____________________ Cell: _____________
Work phone: ____________________________ Ext. _______

HOW DID YOU HEAR ABOUT US?

____

DENTAL INSURANCE- PRIMARY

Name of Policy Holder: _______________________________
Date of Birth: ________/________/________
Social Security Number: ________-________-________
Policy Holder's Address: ______________________________
Relationship to patient: ______________________________
Employer: ____
Insurance Company: _________________________________
Address: ____________________________________
City: ______________ State: _________ Zip:_______
Phone: _____________________________________
ID Number: __________________________________
Group Number: _______________________________
Group or Union Name: _______________________________

DENTAL INSURANCE- SECONDARY

Name of Policy Holder: _______________________________
Date of Birth: ________/________/________
Social Security Number: ________-________-________
Policy Holder's Address: ______________________________
Relationship to patient:_______________________________
Employer:____
Insurance Company: _________________________________
Address: ____________________________________
City: ______________ State: _________ Zip:_______
Phone: _____________________________________
ID Number: __________________________________
Group Number: _______________________________
Group or Union Name: _______________________________

OTHERS ON ACCOUNT

__________________________ ______________________
__________________________ ______________________
__________________________ ______________________
__________________________ ______________________

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.
I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Signature of Responsible Party **Relationship** **Date**