SMILE
DESIGN CENTER

PATIENT INFORMATION FORM

5445 Village Dr., Suite 100
Viera, FL 32955
321-751-7775 Fax
321-751-4744

PATIENT Last Name: _____ **First Name:**_____
Preferred Name: _____ **Title:**_____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**
Birthdate: _____ **Social Security Number:**_____
Driver's License Number: _____ **State:**_____ _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
E-Mail Address: _____ **Home Number:** _____
Work Number: _____ **Cell/Pager:** _____
Employer: _____ **Occupation:** _____

Responsible Party Other Than Patient: _____
Relationship to Patient: _____
Home Phone _____ **Work Phone** _____ **Cell/Pager** _____
Address: _____
Birth date: _____ **Title:** _____ **Marital Status:** ❑ **Single** ❑ **Married** ❑ **Other**
Driver's License Number: _____ **State:** _____
Employer: _____ **Occupation:** _____
Social Security Number: _____

DENTAL INSURANCE INFORMATION
Subscriber: _____ **Relationship to Subscriber:** _____
Primary Carrier: _____ **Group Number:** _____
Subscriber ID Number: _____ **Employer:** _____
Address: _____ **Phone:** _____

SECONDARY DENTAL INSURANCE INFORMATION IF APPLICABLE
Subscriber: _____ **Relationship to Subscriber:** _____
Name of Carrier: _____ **Group Number:** _____
Subscriber ID Number: _____ **Employer:** _____
Address: _____ **Phone:** _____

GETTING TO KNOW YOU
How did you hear about us? _____
Purpose of this appointment? _____
Person to contact in case of emergency? _____

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. Also authorizes the Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk, Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. Lastly I understand that all responsibility for payment for myself and dependents is mine.

Signed _____ **Print Name**_____

Date _____ **Witness** _____ **Relationship to Patient** _____