New Patient Form

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Beaumont Smile Center
EXCELLENCE IN DENTISTRY

Helene Suh, DDS Gerard Cascio, DDS
Charles Harrell, DDS

Date:

Last Name: First Name: Middle Initial:

Preferred Name: Referred By:

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via text message.

Birth Date: Age: Social Security: Driver's License:

Sex: ❍ Male ❍ Female Marital Status: ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired Student Status: ❍ Full Time ❍ Part Time

Your employer: Your occupation:

Has any member of your family ever been treated in our office? ❍ Yes ❍ No Name:

Pref. Dentist: Pref. Pharmacy Pref. Hygienist

Spouse or Responsible Party
(If someone other than the patient)

Last Name: First Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Driver's License:

Primary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Employer:

Employer ID:

Group #:

Insurance Company:

Address:

City: State: Zip:

Emergency Contact Information

Name:

Relationship: ❍ Self ❍ Spouse ❍ Child ❍ Other

Address:

City: State: Zip:

Phone:

Financial

I understand that I am responsible for all costs of dental treatment regardless of insurance and that late balances are subject to an 18% finance charge. Initial _____

Appointments not cancelled within 48 hours will be subject to a charge. Initial _____

I hereby authorize payment directly to Beaumont Smile Center from the insurance company.