NEW PATIENT FORM

3560 Delaware Street | Suite 102
Beaumont, TX 77706
409.892.2600
www.beaumontsmilecenter.com

Beaumont Smile Center
EXCELLENCE IN DENTISTRY

Helene Suh, DDS Gerard Cascio, DDS

Date:

First Name: Last Name: Middle Initial.

Preferred Name: O Policy Holder O Responsible Party Referred By:

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

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

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

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

Employment Status. O Full Time O Part Time O Retired Student Status. O Full Time O Part Time

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

Pref. Dentist. Pref. Pharmacy Pref Hygienist

Responsible Party
(If someone other than the patient.)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security Driver's License:

O Responsible Party is also a Policy Holder O Primary Insurance Policy Holder

Primary Insurance Information

Name of Insured:

Relationship to Insured. O Self O Spouse O Child O Other

Insured Social Security:

Insured Birth Date:

Employer:

Employer ID:

Group #:

Insurance Company:

Address:

City: State: Zip:

Emergency Contact Information

Name:

Relationship: O Self O Spouse O Child O 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.