Excelsior Smiles

Full Legal Name: _____ **Nickname**:_____
First *MI* *Last*

Male □ **Female** □ **Date of Birth:**_____**Social Security#:** _____
(required for all patients 18yrs+)

Home#:_____ **Work#:**_____ **Cell#:**_____

Address:_____

Email Address: _____

Emergency Contact Name:_____**Phone #:**_____

Whom may we thank for referring you? _____

For Patients Under 18:

Parent/Guardian Name:_____**Phone#:** _____Social Security #_____

Address(If different from above):_____Date of Birth_____

Do you have Dental Insurance? YES NO

Dental Insurance Co._____ Group#_____ ID#/SS#_____

Subscriber Name_____Subscriber Date of Birth_____ Employer_____

Additional (Secondary) Insurance

Dental Insurance Co._____ Group#_____ ID#/SS#_____

Subscriber Name_____Subscriber Date of Birth_____Employer_____

I understand that I am responsible for all costs of dental treatment, regardless of any insurance, and/or financial situations.

Signature of Responsible Party:_____ Date_____

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