PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____

CITY, STATE, ZIP: _____

PRIMARY PHONE (type): _____ 2nd PHONE (type): _____

PATIENT SSN: _____ SEX: ___ MALE ___ FEMALE

EMAIL: _____

____ I WOULD LIKE TO RECEIVE CORRESPONDANCE BY EMAIL

____ I AM ABLE TO ACCEPT TEXT MESSAGES

EMERGENCY CONTACT AND NUMBER: _____

RESPONSIBLE PARTY NAME: _____DATE OF BIRTH: _____

RESPONSIBLE PARTY ADDRESS: ___ SAME AS ABOVE (IF DIFFERENT, PLEASE COMPLETE BELOW)

ADDRESS: _____

CITY, STATE, ZIP: _____

HOW DID YOU HEAR ABOUT INFINITE SMILES? _____

PRIMARY INSURANCE INFORMATION ***** PLEASE PRESENT COPY OF INSURANCE CARD *****

NAME OF INSURED: _____DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

NAME OF INSURANCE CARRIER: _____

NAME OF INSURED EMPLOYER: _____

INSURED SOCIAL SECURITY NUMBER OR MEMBER ID: _____

GROUP NUMBER: _____