

# BELMAR SMILES

GENERAL DENTISTRY. THE AESTHETIC WAY.

## Patient Information

Name: \_\_\_\_\_  
Last First Middle  
E-Mail: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_

## Responsible Party Information (If Patient is a Dependent)

Name: \_\_\_\_\_  
Last First Middle  
E-Mail: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street City State Zip  
Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
Driver's License or ID Number: \_\_\_\_\_

## Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Holder: \_\_\_\_\_  
Last First Middle  
Primary Holder's DOB: \_\_\_/\_\_\_/\_\_\_\_ Primary Holder's SS/MemberID: \_\_\_\_\_  
Primary Holder's Employer: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_

## Emergency Contact Information

Local Friend or Relative not Living With You: \_\_\_\_\_  
Emergency Contact Phone Number: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact Address: \_\_\_\_\_

## Getting to Know You:

How did You Hear About Us?  Search Engine  Friend  Family  Social Media  
If Referred by Friend or Family, Who may we Thank: \_\_\_\_\_  
Last First  
When was your Last Dental Visit: \_\_\_\_\_ X-Rays: \_\_\_\_\_  
Have you ever had any teeth removed and how long ago: \_\_\_\_\_  
Have they been replaced?  Bridge  Implant  Denture  No replacement

## FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor/or his staff. I agree to pay for all services rendered by this office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_