Kyle A. Smits D.D.S., PLLC

PATIENT'S NAME: ____**Birthdate:**_______________**SS**.#________________________

Circle: **M** or **F** Single, Married, Widow **Email Address**:____

Phones: H_____________________**W**____________________**C**_________________________ **Preferred # to call**: H W C

Billing Address:____City___________________State___________Zip_______

Street Address if different from billing:____

Employer____Address____

SPOUSE OF PATIENT:_____________________________________**Birthdate:**____________**SS#**___________________________

Phones: H ______________________**W**______________________**Other**____

Employer____Address____

Responsible party, if different from above or if patient is a child or dependent.

PERSON RESPONSIBLE FOR ACCOUNT:______________________________________**Relationship to patient**______________

Address:____City________________________State_____Zip____________________

Phones: H________________W_________________C_______________________SS#________________Birthdate________________

Employer____Address____

PRIMARY DENTAL INSURANCE
Ins. Co.:____
Subscriber's name:________________________________
Subscriber's Birth Date:___________________________
Patient relationship to Insured:_______________________
Group#_____________ID#_________________________

SECONDARY DENTAL INSURANCE
Ins. Co.:____
Subscriber's name:___________________________________
Subscriber's Birth Date:______________________________
Patient relationship to Insured:_________________________
Group#________________ID#_________________________

I was referred to Dr. Smits office by: (circle one)

Dental Office Yellow Pages PPO List Current Patient Web Site Other

Name of person or office referring you to our practice:____

I have completed this information and medical history, and to the best of my knowledge have answered all questions correctly, I will advise Dr. of any changes including medical history and medications. I hereby authorize Dr. Smits office to submit insurance claims on patient's behalf without my signature after completion of dental service and whether or not there are insurance benefits, I understand that I am ultimately responsible for payment of this account; I authorize payment of insurance benefits directly to Dr. Smits. If I receive an insurance check and have an outstanding balance, I agree to immediately endorse and send the check to our dental office. Account fees carried **60 days or more** will accrue interest at **1%/month –12% annual**. Accounts not paid in a timely manner may be turned over for professional collection. I authorize the Dr. or insurance company to release any relevant information for account collection or to other providers involved in my healthcare.

We understand that emergencies may arise that may prevent you from keeping an appointment, but as our office strives to treat patients in a timely manner, we expect the courtesy to be returned. A minimum **48 hour notice** must be given to avoid a **cancellation/"No Show" fee of $25 per ½ hour** of the scheduled appointment time.

SIGNATURE____ DATE ______________________