

## Sweet Smiles MT Pleasant

1515 South Greenbay Road, Mount Pleasant WI 53406

Thank you for visiting Sweet Smiles. We want your visit to be pleasant and comfortable. Please help us by completing this form.

### Patient Information

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Preferred Name: \_\_\_\_\_

**Address:** Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Employer: \_\_\_\_\_

Driver License #: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Marital Status:  Married  Single

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  Male  Female

**Phone Numbers:** Home: (\_\_\_\_) - \_\_\_\_\_ Work: (\_\_\_\_) - \_\_\_\_\_ Cell: (\_\_\_\_) - \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_

**How did you hear about us?**  Yellow Pages  Google  Yahoo  Walk in/Drive by  Insurance  Mailer

Referred By: \_\_\_\_\_  Other: \_\_\_\_\_

### Insurance Information

**Primary Dental Carrier:** Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Secondary Dental Carrier

Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

If Patient Is Under 18 Years of Age

Responsible Party \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**I certify that the information on this page is correct to the best of my knowledge.**

**Date:** \_\_\_\_\_

**Signature (Patient or Parent/Guardian):** \_\_\_\_\_