

Kyle A. Smits D.D.S., PLLC
Paul K Smits D.D.S., P.S.

PATIENT'S NAME _____ Birthdate _____ SS.# _____

Circle: M or F//Single,Married,Widow Phones: H _____ W _____ C _____

Billing Address _____ City _____ State _____ Zip _____

Street Address if different from billing _____

Employer _____ Address _____

SPOUSE OF PATIENT _____ Birthdate _____ SS# _____

Phone 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 _____

SPOUSE OF PERSON RESPONSIBLE _____

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.

SIGNATURE _____

DATE _____