KYLE A. SMITS DDS
West Seattle Dentistry

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 Online Reviews PPO List Current Patient Web Site Other

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

By providing your wireless phone number and/or email, you agree and give consent to receive communication form the office of Kyle A. Smits DDS PLLC via text message and/or email. If you choose to not receive text or email messages, please check this box: ☐

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 $50 per ½ hour** of the scheduled appointment time as of 2025 – we reserve the right to increase this fee on a yearly basis

SIGNATURE_____ DATE_____