LA SMILES
Dental Spa

**PATIENTS INFORMATION**

Last Name_____ First Name_____ M.I._____
Date of Birth _____ Social Security # _____ Sex: M___ F___
Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Other ___

Address _____ Apt. # _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____

Driver License # _____State _____ Exp. Date _____

Employer _____ Occupation _____
Name of Spouse _____ Occupation _____

Name of Parents (if under age) _____
Name of School (for Dependent children) _____ City _____

**RECOMMENDATIONS**

Referred By: Patient__ Internet __ Other __ If by patient, name _____

**POLICY HOLDERS INFORMATION**

Last Name _____ First Name _____
Date of Birth _____ Social Security # _____

Or Subscriber ID #_____

Insurance Name _____ Insurance Tel. #_____
Employer_____ Occupation _____
Address_____
City_____ State_____ Zip Code_____

In Case of Emergency, Please call:_____ Tel. #_____

I hereby authorize the release of any information including the diagnosis and the records of any treatment, or examination rendered to my insurance company. The release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled. Authorization is hereby granted to LA Smiles Dental Spa to release information for appropriate credit verification and patient information required.

Signature of Patient _____ Date_____