

Welcome to Shadyside Smiles

Family and cosmetic dentistry
Dr. Christina R. Schmeler

Patient's Name _____
Last First MI

How would you like to be addressed? _____ Birthdate _____ Sex Male Female

Social Security Number _____ Student Yes No School _____

Patient Email _____

Home Address _____
Street City State Zip

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____
Area Code Number Area Code Number Area Code Number

Employer _____
Company Name Occupation Phone

Who referred you to our office? _____
First Name Last Name

Dentist _____
First Name Last Name Location

Physician _____
First Name Last Name Location

Orthodontist _____
Name Location

Spouse (if applicable) _____
Name Social Security Number Birthdate
Employer/Company Name Occupation Phone

Primary Dental Insurance Company

Employer _____

Bus. Address _____
Street City State Zip

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____
First Name Last Name Relation

Sex: Male Female Birth Date _____

Street _____ City _____

State _____ Zip _____ Tel. (_____) _____

S.S. # _____ I.D. # _____

Secondary Dental Insurance Company

Employer _____

Bus. Address _____
Street City State Zip

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____
First Name Last Name Relation

Sex: Male Female Birth Date _____

Street _____ City _____

State _____ Zip _____ Tel. (_____) _____

S.S. # _____ I.D. # _____

Primary Medical Insurance Company

Employer _____

Bus. Address _____
Street City State Zip

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____
First Name Last Name Relation

Sex: Male Female Birth Date _____

Street _____ City _____

State _____ Zip _____ Tel. (_____) _____

S.S. # _____ I.D. # _____

Secondary Medical Insurance Company

Employer _____

Bus. Address _____
Street City State Zip

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____
First Name Last Name Relation

Sex: Male Female Birth Date _____

Street _____ City _____

State _____ Zip _____ Tel. (_____) _____

S.S. # _____ I.D. # _____

Who is insurance coverage under? (check all applicable) () Self () Spouse () Mother () Father () Other

PLEASE PROVIDE ALL INSURANCE CARDS/FORMS BOTH MEDICAL AND DENTAL FOR COPYING. THANK YOU

Please sign where indicated by "X" otherwise, payment in full is due when services are rendered

I authorize The Provider Named Above To Release Any Information Required To Process This Account. I understand that when appropriate credit reports may be obtained.

X
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I authorize Payments Of Insurance Benefits To Be Made Directly To The Provider Named Above. I Am Financially Responsible For All Medical Services.

X
SIGNED (INSURED PERSON) DATE