GATEWAY SMILES
FAMILY DENTISTRY

PATIENT INFORMATION

Today's Date: ___/___/___

Patient Name: _____ Date of Birth: ___/___/_____

Sex: ☐ M ☐ F ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced

Soc. Sec. #: _____-_____-_____ Drivers Licence #:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (____) _____ Cell Phone: (____) _____

Email Address: _____

Occupation: _____

Employer Name : _____

What is your preferred method of communication? _____

I give permission to receive texts messages and emails regarding appointments and other office communications **YES / NO** *Signature of responsible party*:_____

Emergency Contact: _____

Relationship to patient: _____

Phone #:_____

Primary Care Physician and phone number:

_____

How did you hear about us? _____

INSURANCE INFORMATION

Policy Holder: _____ DOB: _____

SS#: ____-_____-_____ Relationship to Patient: _____

Insurance Company & phone #: _____

Subscriber I.D. #: _____Group #: _____

Group Name: _____ or Employer_____

FINANCIAL POLICY

Thank you for choosing Gateway Smiles Family Dentistry as your dental provider. Our primary goal is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable as possible for our patients. To do this we are offering several different payment options.

Payment options:

- Cash, check or card (Visa, Mastercard, American Express, Discover card, HSA card)

Please note: Gateway Smiles Family Dentistry requires payment in full at the time of your treatment.

For patients with in-network dental insurance, you are required to pay your estimated copayment at the time of the visit. If the remaining balance is not paid by your insurance carrier, you are responsible for the remaining balance. For patients without in-network dental insurance, after you have paid for your services in full, we are happy to work with your insurance carrier to maximize your benefits by helping you directly bill them for the reimbursement of your treatment. If you have any questions, please do not hesitate to ask us.

_____ _____

Patient, Parent or Guardian signature Date