All About Smiles
2476 E Euclid Ave
Des Moines, IA 50317

First Name: _____
Last Name: _____
Middle Initial: _____
Preferred Name: _____

Patient Information

Street Address: _____ City: _____ State: ___ Zip Code: _____

Home Phone#: _____ Work Phone#: _____ Cell Phone#: _____

Birth Date: _____ Social Security#: _____ Drivers License#: _____

Email Address: _____

Spouse's Name: _____ Spouse's Employer: _____

Phone #: _____

Emergency Contact (Name and Phone #) _____

Responsible for Payment (if someone other than patient)

Full Name: _____ Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Work Phone#: _____ Cell Phone#: _____

Birth Date: _____ Social Security#: _____ Drivers License#: _____

Signature of Responsible Party: _____

Primary Dental Insurance

Employer: _____

Insurance Company Name: _____

Subscriber Name: _____

Subscriber ID #: _____

Mailing Address: _____

(If different than patient)

Secondary Dental Insurance

Employer: _____

Insurance Company Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Mailing address: _____

(If different than patient)

Assignment of Benefits

I hereby assign any insurance benefits to be paid directly to All About Smiles, PC; Dr. David Motz

_____ _____

Patient's signature Date

(If the patient is a minor, parent's signature is required)

All About Smiles, PC Payment Request

It is requested of all our patients to pay their Estimated Co-Payment and Deductible at the time treatment is received. If necessary, you may establish a payment arrangement Prior to the start of Treatment with the Office Manager.

_____ _____

Patient's signature Date

(If the patient is a minor, parent's signature is required)

May 2010