GENTLE TOUCH SMILES

WELCOME!

Our goal is to make every visit pleasant and educational. Our practice is based on preventive care. We strive to teach excellent oral health care to produce beautiful smiles that will last a lifetime!

PATIENT INFORMATION

Patient Name_____ Nickname_____

○ Male ○ Female Birth date____/____/____ SS#_____

Home Address_____Apt#_____City/State/Zip_____

Home Phone_____ Cell_____Other_____

Previous Dentist_____ Last visit date_____

○ My family is NEW to Gentle Touch Smiles ○ Please add to EXISTING family file_____

Emergency contact_____Relation_____Phone_____

If under 18 → Legal Guardian_____ Relation_____

Who is accompanying the child today? _____ Relation_____

Email_____ Who may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

State of DE Medicaid

○ Under 21: MMC# _____

○ Over 21: UnitedHealth Care ID#_____

*******You may SKIP to RELEASE******

No Insurance

○ Cash Pay

○ I currently have CareCredit

○ I would like information regarding CareCredit

*******You may SKIP to RELEASE******

COMMERCIAL DENTAL INSURANCE/OTHER

Primary Insurance Co._____Ph#_____

Subscriber Name_____ Relation to patient_____ Birth date____/____/____

Home Address_____Apt#_____City/State/Zip_____

SS#_____ Member ID#_____Group#_____

Employer_____ Phone_____ Address_____

Secondary Insurance Co._____Ph#_____

Subscriber Name_____ Relation to patient_____ Birth date____/____/____

Home Address_____Apt#_____City/State/Zip_____

SS#_____ Member ID#_____Group#_____

Employer_____ Phone_____ Address_____

*****RELEASE*****

I understand that I am responsible for payment of services rendered & also responsible for paying any co-payment & deductibles that my insurance does not cover. I hereby authorize my insurance company to send payment(s) directly to Gentle Touch Smiles, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the release of any & all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient/Parent/Guardian Signature _____**Date**_____

THANK YOU FOR CHOOSING GENTLE TOUCH SMILES