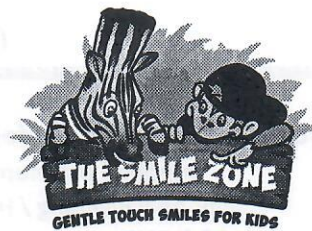


## GENTLE TOUCH SMILES



### 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# \_\_\_\_\_

No Insurance  
☐ Cash Pay  
☐ I currently have CareCredit  
☐ I would like information regarding CareCredit

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

\*\*\*\*\*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

