



# Smile In Style Dental Studio

Steve Buchanan D.D.S.  
Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely.  
If you have any questions or concerns, do not hesitate to ask for assistance.

## Patient Information

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ (office use only)

Name \_\_\_\_\_ Prefers to be Called \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work # \_\_\_\_\_ Ext \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex: M/F \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Partnered \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

How did you learn about us? SW Bell \_\_\_\_\_ Feist/Yellow Book \_\_\_\_\_ Website \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone # \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  Yes  No IF YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_