Healthy Smiles Winter Park

Stuart Dropkin, D.M.D., PA

PATIENT INFORMATION

Date ____________________ Male ☐ Female ☐

Patient's Name ____
Last First Middle

Address ____
Street City State Zip

Social Security # ____________ Birthdate ____________ Home Phone ____________

If patient is a minor, give parent's or guardian's name ______________________

Who referred you to our office? ______________________

Cell # ____________________ Email ____________________

Preferred method of confirming appointment— (circle one) Home Phone/Cell Phone/Work Phone/Text/Email

RESPONSIBLE PARTY INFORMATION

Name ____

Address ____

No. years at this address ____________ Home Phone ____________ Work Phone ____________

EMPLOYMENT INFORMATION

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ______________________ Occupation ____________

Employer's Address ______________________ Work Phone ____________

Spouse's Name ______________________ Spouse's Birthdate ____________

Spouse's Employer ______________________ Spouse's Employer's Address ____________

Occupation ______________________ Spouse's Work Phone ____________

DENTAL INSURANCE INFORMATION

Insured's Name ______________________ Insured's Soc. Sec. # ____________

Insurance Company ____________ Group # ____________ Member # ____________

Insurance Co. Address ____

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________ Relationship ____________

Complete Address ____

Phone ______________________________

Signature (Parent's signature if minor) ______________________________

Up dates (date & initial) ______________________________

STATEMENT

NOTICE:

Until your insurance has been verified, you are responsible for all charges at the time of service. We will gladly accept cash, check, or credit card for payment.

Signature ______________________________