Oshkosh Smiles
FAMILY & COSMETIC DENTISTRY

➢ PATIENT INFORMATION

Name _____ Today's Date ____ / ____ / _____
First Last MI

Address_____City_____State_____Zip_____

E-mail address_____ Home Phone#_____

☐ Your Cell Phone#_____ ☐ Work Phone#_____
Please check the best way to contact you to confirm your dental appointments. May we call you at work with dental-related questions? ☐Yes ☐No

Employer_____

Sex: ☑M ☐F Birthdate ____ / ____ / _____ ☐ Single ☐ Married ☑ Widowed

SSN (if over 17yrs) _____ ☐ Separated ☐ Divorced

If a full-time student: School _____ City_____

Person Responsible for Account Balance_____ Relationship to Patient_____

Address _____ City _____ State _____ ZIP _____

Please check how you will be paying for your treatment: ☐CARE CREDIT (extended payments with no interest) OR CASH☐ CHECK☐ CREDIT/DEBIT CARD☐ (5% discount is given for payment **in full** the same day as services)

➢ DENTAL INSURANCE INFORMATION (If you have a card, we'd like to make a copy)

Employee_____ Employer_____

Employee Birth date____ / ____ / _____ SSN_____ Relationship to Patient_____

Insurance Company _____ Insurance Address_____

ID# (or SSN if no ID#) _____ Group#_____

➢ ADDITIONAL DENTAL INSURANCE INFORMATION (If patient is covered by more than one plan)

Employee_____ Employer _____

Employee Birth date ____ / ____ / _____ SSN _____ Relationship to Patient_____

Insurance Company _____ Insurance Address _____

ID#(or SSN if no ID#) _____ Group#_____