VILLAGE SMILES
Deborah Gadille, DDS

PATIENT INFORMATION

First Name _____ Middle Initial ____ Last Name _____
Gender _____ Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____
Do you prefer calls at: Home _____ Work _____ Cell _____
To receive E-Mail correspondence, please provide your E-Mail address

_____
Employer _____ Employer Address _____
If patient is a student, name of school or college _____
Whom may we thank for referring you to our practice? _____
Former Dentist _____ Address _____
Emergency Contact _____ Phone (_____) _____

RESPONSIBLE PERSON

Responsible Person's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Employer _____ Social Security Number _____
Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____

SPOUSE

Name _____ Date of Birth _____
Employer _____ Employer Address _____
Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Policy# _____
Company Address _____ Phone (_____) _____
Insured's Name _____ Group# _____

Secondary Insurance Company _____ Policy# _____
Company Address _____ Phone (_____) _____
Insured's Name _____ Group# _____

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents or charges.

X _____ Date _____
Signature of patient, parent if minor or guardian of adult under guardianship Mo. Day Yr.