Southern Ohio Smiles

Welcome to Southern Ohio Smiles- Tell Us About Yourself

Name: _____
Last First Mi Title

Preferred Name: _____Male_____ Female_____

Address: _____City_____ State_____ Zip_____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E- Mail Address: _____

Employer: _____ Occupation: _____

Marital Status: Single_____ Married_____ Divorced_____ Domestic Partner_____

How did you hear about our office? _____

Do you prefer to be contacted for appointment via e- mail or phone? _____

Insurance Information

Subscriber Name:_____ Relationship to Patient:_____

Subscriber D.O.B._____ Subscriber Employer:_____

Name of Insurance Company:_____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to obtain payments of benefits. I authorize the use of this signature for all insurance submissions.

Responsible Party Signature:_____

Relationship to Patient:_____ Date:_____