Dr. Gremillion
New Patient Account Form

Dino Smiles

DINO SMILES

| Patient Name | ☐ Male ☐ Female | Date of Birth |
|---|---|---|

Address _____ City _____ _____

State _____ Zip _____ Home Phone _____

Email Address _____

Child's School _____ _____ Sibling Names _____

Hobbies _____

Mother's Name _____ Mother's Cell Phone _____

Mother's S.S. No. _____ Mother's D.O.B. _____ Employed By _ _____

Father's Name _____ Father's Cell Phone _____

Father's S.S. No. _____ _____ Father's D.O.B. _____ _____ Employed By ____ _____

How did you hear about our office? _____

In order to expedite your dental claim, the section(s) below must be filled out completely.

## PRIMARY DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

## SECONDARY DENTAL INSURANCE ☐ N/A (Not Available)

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

In case of emergency, please list the name, phone number and relationship to the patient not living at home:

_____

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any/and all necessary dental services be rendered. Authroization is hereby granted for Dino Smiles to provide dental care for this child. Furthermore, I acknowledge receipt of the office policy as to charges and payments and agree to comply. I will be financially responsible for the charges incurred for the dental treatment of this child.

Signature of Parent/Guardian _____ Relationship to Patient _____

Print Name _____ Date _____