

# The Smile Zone

576 Sand Creek Road

Albany, NY 12205

(518)869-5348



## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:

Last

First

MI

Preferred Name

Title:

Mr/Ms/Mrs/etc

Gender:

☐

Male

☐

Female

Family Status:

☐

Married

☐

Single

☐

Child

☐

Other

Birth Date:

SS #.

Prev. Visit:

Email Address:

Best time to call:

Phone:

Home

Work

Ext

Mobile

Fax

Other

Address:

City

State

Zip Code

Name of person, office, or other source referring you to our practice:

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## Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: \*  \*     
Last First MI Preferred Name

Title:  Gender: \* ☐ Male ☐ Female Family Status: \* ☐ Married ☐ Single ☐ Child ☐ Other  
Mr/Ms/Mrs/etc

Birth Date: \*  Email Address:

Phone: \*     Best time to call:   
Home Work Ext Mobile

Address: \*    
\*  \*  \*   
City State Zip Code



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## Primary Insurance Information

### Primary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

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## Secondary Insurance Information

### Secondary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code



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## Consent for Services

As a condition of my treatment by The Smile Zone I understand that I am financially responsible for payment of all dental services.

I realize that failure to keep this account current may result in being unable to receive additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable fees incurred in attempting to collect on this amount or any future account balance.

I understand a fee of \$50 is charged if I cancel an appointment more than 2 times without 48 hours notice. For larger, more comprehensive treatment plans, if I break an appointment, a \$100 deposit is required to secure my next appointment.

I acknowledge The Smile Zone charges \$35 for all returned checks.

Insurance is a contract between you and the insurance company. We will work with your carrier to maximize your benefits; however you are responsible for the timely payment of your account. Deductibles, co-payments and co-insurances are due at the time of services, unless otherwise noted.

I hereby authorize The Smile Zone to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employer/spouse/parent with my insurance company. I hereby authorize payment of dental benefits otherwise payable to me directly to the office of The Smile Zone. This "signature on file" will be valid as long as this insurance is in effect and I am an active patient of record. A photocopy of this document may act as an original

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature: \_\_\_\_\_

Date:

Name of person completing this form:

Relationship to Patient: