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: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ 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 Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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 undestand that there is a $35 fee 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. Account balances over 60 days past due are subject to a $25 late fee monthly.

In order for us to provide comprehensive care, full mouth x-rays are required at your new patient appointment, regardless of insurance coverage.

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** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____