

The Smile Zone

info@smilezonealbany.com

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 that there is a \$35 fee for all returned checks.

We strive to provide every patient with the attention and care they need; as such when scheduling an appointment, we reserve that time specifically for you. If you must cancel an appointment, we require 48 hours notice. After 2 same day cancellations or no shows within one year a warning will be given that with the third late cancellation or no show, we may choose to dismiss you from the practice.

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

Signature _____ Date _____

Relationship to Patient:

Response Date: _____