



## PATIENT INFORMATION

Welcome to Green Bay Smiles! To assist us in serving you, please complete the following confidential form.  
The information provided is important to your dental health.

**Patient's Name** \_\_\_\_\_ Preferred name \_\_\_\_\_  
Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ If minor, parents names \_\_\_\_\_  
Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Other \_\_\_\_\_

Email address \_\_\_\_\_  
Would you like to receive text/email appointment confirmations and reminders? (Circle One) YES NO

**Emergency Contact:**

Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**INSURANCE INFO:**

Name of Primary Insurance Company \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Birth Date \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Subscriber employed by \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_

Name of Secondary Insurance Company \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Birth Date \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Subscriber employed by \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_

I currently DO NOT have any dental insurance



**APPOINTMENTS:**

We value your time, so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time, since we reserved this time just for you. If you must change an appointment, please provide us at least *2 working days advanced notification* so that we may accommodate other patients. We value your time, please value ours.

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**FINANCIAL POLICY:**

At Green Bay Smiles we care about you and your dental health, so we offer choices for paying for your dental care. We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and Third Party Financing (if approved) through Care Credit.

**We can help with discounts:**

If you do not have dental insurance, we offer a **5% discount** if paid by cash or check the same day as service. We offer a **3% discount** if paid by credit card.

**Insurance Policy:**

All insurance co-pays and deductibles must be paid at or before the time of service. We will submit all pertinent information electronically to your insurance company and help you to maximize your dental benefits while receiving your personalized dental care. In the event that we do not get payment from the insurance company, the balance will be required to be paid by you.

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**ACKNOWLEDGEMENTS (please initial):**

\_\_\_\_\_ I authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_ I authorize the dentist to release all information necessary to secure the payment of benefits.

\_\_\_\_\_ I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_ I have read and acknowledge the above Financial Policy.

\_\_\_\_\_ Payment is due in full unless prior arrangements have been approved.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT/RESPONSIBLE PARTY'S SIGNATURE** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_