All Smiles Family Dentistry
Ilona K. Furman, D.D.S., P.S.

PATIENT CONFIDENTIAL INFORMATION

Last name: _____ First name: _____ M.I.: _____

Date of Birth:____/____/_____ Sex:_____ Age:_____ SS#:_____-_____-_____

Circle one: Married Single Minor Widowed Domestic Partner

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell: _____

E-mail Address:_____

Emergency Contact Name:_____ Phone:_____

Employer:_____ Occupation:_____

I was referred to your office by:_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:_____ Group #:_____

Are you the Primary Subscriber? Yes No

Subscriber's Name:_____ Date of Birth:___/___/_____

Subscriber's SS#:____/____/_____ Member's ID #:_____

Do you have Secondary Insurance? Yes No

FINANCIAL POLICY AND PATIENT OPTIONS

We Accept: Cash, Check, Credit, Debit

Patient Who Have Dental Insurance: Insurance estimate is NOT a guarantee of payment, we do a courtesy check for you.

Payment Plan Option: In house financing, Interest-free! Up to 6 payments. Please ask for details.

Care Credit Payment Option: Up to 12 month financing. Please ask for details.

Missed Appointment: Requires 24 hours to avoid a $50 non-refundable charge!

Referrals: $25 Credit! The greatest compliment you can give us is to refer a family, friend or collegue.

Printed Name:_____ **Signed:**_____

Today's Date:____/____/_____