

Steven E. Smith DDS MAGD

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(520)229-3579

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: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

How would you like to have your appointment reminders sent to you?

Phone Text Message Email

Whom may we thank for referring you to our practice?

Dental Office Yellow Pages Internet Newspaper School Work
 Other (name below): _____

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

Insurance Information

Subscriber ID or Social Security Number

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 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

Relationship to Patient:

Response Date: _____