Patient Information Form **Date:**_____

FAMILY SMILES
OF THE HUDSON VALLEY

Patient Information

Patient Name:_____
Last First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender:_____

Address:_____
Street Apartment

City:_____ State:_____ Zip:_____

Home #: _____ Work #:_____Ext:_____ Cell #:_____

Email:_____**Preferred Method of Communication: ___Email ___Text ___Cell# ___Home#**

Insurance Information

Employed By:_____ Dental Insurance through this company?: ☐ Y ☐ N

Name of Insurance:_____ Address of Insurance:_____

Group Number:_____ I.D. Number:_____

Responsible Party Information

Parent/Spouse Name:_____ Birth Date:_____ S.S. #:_____

Address(if different):_____
Street City State Zip Code

Home #: _____ Cell #: _____ Work #: _____

Email Address:_____

Parent/Spouse Employed By:_____ Dental Insurance through this company: ☐ Yes ☐ No

If Yes, Name of Insurance:_____ Policy #:_____ Group #:_____

Address of Insurance:_____

Who do you authorize Family Smiles of the Hudson Valley to speak with regarding your dental/financial information:

Name(s):_____

Whom shall we contact in case of emergency:_____

Relationship:_____ Home #:_____Cell #:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:_____ **Date:** _____