Aesthetic Smiles
Wade Pilling D.M.D.

Patient Information

Last Name _____ First Name _____Date_____
Marital Status _____ Spouses Name _____
Patients Date of Birth ___/___/___ Patients Age _____ Patients SS# _____-____-_____
Spouses Date of Birth ___/___/___ Spouses Age _____ Spouses SS # _____-___-_____
PO Box _____ Street Address _____ ____City _____
State _____ Zip Code _____ Home Phone _____ ___Cell Phone _____
Occupation _____ Employer _____ _____Employer Phone _____
Employer Address _____
Person Responsible for bill?
Name _____ Address if different _____
Phone Number _____ SS # ____-___-____ Date of Birth ___/___/____
Whom may we thank for your referral? _____
Email Address_____

Insurance Information

Name of Insurance _____ Relationship to Subscriber _____
Subscribers Name _____ SS# ___-___-___ DOB ___/___/___
Employer _____ Employer Phone _____
Employer Address _____ Effective Date _____
Group Number _____ Policy Number _____
Insurance Phone Number _____

Secondary Insurance _____Relationship to Subscriber _____
Subscribers Name _____SS# ___-___-___ DOB ___/___/___
Employer _____ Employer Phone _____
Employer Address _____ _____Effective Date _____
Group Number _____ Policy Number _____
Insurance Phone Number _____

In Case Of Emergency

Name of a Local Friend or Relative _____ Relationship_____
Home Number _____Work Number_____

Disclosure

The above information is true and correct to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Wade Pilling. I understand that I am financially responsible for any balance,. I also authorize Dr. Wade Pilling to release any information necessary to process my insurance claims

Print Name Signature Date