CitySpireDental

Last Name: ____________ First Name: ____________ MI: ______

Birth Date: ____________ Preferred Name: ____________
Gender Identity: ____________ Preferred Pronoun: ____________

Salutation: Mr. Mrs. Ms. Dr. Marital Status: Single Married Widowed Divorced Partnered

Street Address/State/Zip ____________

Home/Mobile: ____________ Email: ____________

Emergency Contact ____________

Who may we thank for referring you? ____________

Do we treat any other members of your family? ____________

The purpose of my visit is ___ ____________

Are you satisfied with the appearance of your smile? Yes No

What, if anything, about your smile would you like to change? ____________

If you have dental benefits and would like us to submit for you, please provide the following:

Policy holder name: ____________ Policy holder's Date of Birth: ____________
Relationship to Patient: ____________ Dental Carrier: ____________
Subscriber ID or SS# : ____________ Dental Carrier Phone # ____________

If patient is a minor or someone other than the patient is responsible for the account, please provide the following information:

Name of responsible party: ____________ Relationship ____________

Street Address ____________ Phone: ____________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Date: ____________ Signature: ____________

Signature of guardian:____ Date: ________________
(for patients under eighteen)