Dentistry Divine Smile, Inc.

119 N. 8th St. Deming, NM 88030 Phone: (575)544-8381 Fax: (575)546-0410

Date: ______/ ______ / _________

Patient Name: ____ **Gender:** **M F**
Last First MI

Date of Birth: ______/ ______ / _________ **SSN#:** ________ - _______ - ________ **Marital Status:** ____________

Primary Phone # _______-_______ - _______ **Additional Contact #** _______-_______ - _______

Address: _______________________________ **City/State:** ____________________ **Zip code:**____________

Custodial Parent/Guardian Name: ____

Other Parent/Guardian Name: ____

Insurance Information

PRIMARY

Name of Insured: ______________________________ **Insured's Birth Date:** ______/ ______ / _________

Insurance name: ______________________________ **Subscriber ID#:** ____________________

Patient's Relationship to Insured: Spouse _____ **Child** _____ **Other** _____

SECONDARY

Name of Insured: ______________________________ **Insured's Birth Date:** ______/ ______ / _________

Insurance name: ______________________________ **Subscriber ID#:** ____________________

Patient's Relationship to Insured: Spouse _____ **Child** _____ **Other** _____

I give Dentistry Divine Smile Inc. consent for dental treatment. As the patient or guardian of the patient, I understand that I will be responsible for any payment/insurance co-payment due the day service is rendered. I also understand that as a service to me, Dentistry Divine Smile Inc. will bill my insurance and that I will be responsible for anything my insurance does not pay.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THE CONSENT.

Signature of Patient, Parent, or Guardian: ____________________________ **Date:** ______________

Signature of Guarantor of payment/responsible party: ____________________ **Date:** ______________