Beautiful Smiles Dental LLC
Dental & Denture Clinic
18521 101st Ave NE
Bothell, WA 98011
(425) 487-1551

Patient Information

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out these forms completely in ink. If you have any questions or need assistance, please don't hesitate to ask.

Patient name: _____ Date of birth _____ Sex: ____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing address if different: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone:_____ Work phone: _____

Driver's license #: _____ State: _____ Email: _____

SS #: _____ Employer/Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency phone #: _____

Spouse's name: _____ Spouse's phone #: _____

Primary dental insurance: _____ Group #: _____ ID #: _____

Secondary dental insurance: _____ Group #: _____ ID #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

If Student, Name of School/College _____ City _____ State ____ Zip: _____

Responsible Party: Self _____ Other: Name _____ Relationship _____

Whom may we thank for referring you?/ How did you hear of our office? _____

1. Payment in full or validated insurance coverage along with estimated co-payment is due at the time of service.
2. As a service to our patients, we will bill your insurance company. If your insurance company fails to pay any outstanding balance, then payment in full is the responsibility of the insured or the person responsible for the account.
3. Arrangements for payment other than payment in full or insurance must be made prior to appointments. Any payment plan must be accompanied by a completed financial statement and promissory note.
4. Balances over 60 days past due will be subject to a finance charge of 1.5% per month (18% APR).
5. There will be a $15.00 charge on each returned check.
6. We ask that a 48-hour notice be given for any cancellation of appointments so that we may fill in that time with someone else who desires to have treatment.
7. There will be a $40.00 per hour charge for broken appointments or cancellations without 48 hours' notice.

I certify that I have read and completed this form to the best of my knowledge and acknowledge all stipulations hereto in.

_____ _____

Signature of patient or legal guardian Date