STUDIO SMILE OF NASHVILLE

Dr. JJ Huang
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Patient Information Form

Today's Date:____/____/_____

Name: (Dr/Mr/Miss/Mrs/Ms)_____
(Please Circle) (First) (M.I.) (Last)

Address: _____
(Street) (City/State) (Zip Code)

Home Phone:_____ **Cell Number:**_____ **Work Number** _____

Date of Birth:_____ **Age:**_____ **Male/Female** **SS#** _____/____/_____
(Month Day Year) (Circle One)

Martial Status: **Single** **Married** **Divorced** **Separated** **Widowed**

EMAIL ADDRESS: _____

Occupation: _____

Employer Name, Address & Phone: _____

Spouse Name: _____ **Spouses Employer:**_____

Emergency Contact: _____ **Address:**_____

_____ **Phone:** _____

—► Referred By: _____

Physicians Name: _____ **Phone:**_____

What is the name and location of your pharmacy? _____
Pharmacy Phone Number: _____

Do you have Dental (or) Medical Insurance ? YES (or) NO

***Insurance must be verified prior to procedure. Patients are responsible for any balance on their account not covered or paid by their insurance. Payment is expected when services are rendered*.**

Insurance	**Dental**	**Medical**
Name of Ins. Carrier	_____	_____
Address	_____	_____
City, State, Zip	_____	_____
Insurance Co. Ph.#	_____	_____
Name of Insured Party	_____	_____
SS#/ D.O.B of Insured	_____/___/_____ _____	_____/___/_____ _____
Group #	_____	_____

I hereby authorize release of any medical or other Information necessary to process this claim.
►

I authorize payment of medical benefits otherwise Payable to me directly to: Laserdent
►

Patient's (or) Authorized Person's Signature

Insured's (or) Authorized Person's Signature