

APPLICATION

PATIENT INFORMATION

Patient's Name: _____ Age _____ Sex: F () M ()
Birthdate: ___/___/___ Social Security #: _____ Email: _____
Home Address: _____
City, State: _____ Zipcode: _____ How long at this address: _____
Home Phone: _____ School: _____ Grade: _____
Patients Hobbies: _____
General Dentist: _____ Dentist Phone: _____
How did you hear about Smile for a Lifetime? : _____

PARENT OR GUARDIAN INFORMATION

Name: _____ Marital Status: _____ Email: _____
Home Address: _____ Own () Rent ()
City, State: _____ Zipcode: _____ How long at this address: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Social Security #: _____ Birthdate: ___/___/___ Relationship to patient: _____
Employer: _____ Occupation: _____
Household income (per year): _____ How many living at this address?: _____

DENTAL INSURANCE INFORMATION

Do applicants qualify for NC Health Choice or Medicaid? Y or N
Is applicant covered by dental insurance? (specify company and policy):

ADDITIONAL INFORMATION

Application submitted by: _____ Relationship: _____
Email: _____ Phone Number: _____

