6025 N Green Bay Ave
Glendale, WI 53209

Phone: (414)228-3000
Website: smilewi.com

WELCOME TO
Joyce FAMILY DENTISTRY

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
LAST FIRST INITIAL
If Child: Parent's Name _____

How do you wish to be addressed? _____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐
Address _____
STREET APT

_____
CITY STATE ZIPCODE

Home _____ Work _____
Fax _____ Cell _____
Email _____

Patient/Parent Employed By _____
Name of Insurance Company: _____
Group # _____
Member ID # _____
Mailing Address:_____
Insurance Phone Number: _____
Subscribers' Name _____
Subscriber's date of birth: _____

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card
Purpose of Call _____
Other Family Members in this Practice_____
Whom may we thank for this referral _____
Patient/Parent Social Security No. _____
Spouse/Parent Social Security No. _____
Someone to notify in case of emergency not living with you _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's) to the following persons who are involved in my care (or my child's care) or payment for that care.

Patient/Parent Signature: _____ Date: _____

My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.
I attest to the accuracy of the information on this page.

Patient/Parent Signature: _____ Date: _____