Scott W.W. Steedman, DDS, MPH
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Lake Stevens, WA 98258
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www.SmilesbySteedman.com

Welcome!
We are looking forward to having you join our great group of friends and patients. A beautiful smile radiates confidence, sincerity, and warmth, and your smile truly affects the way that you interact with the world. Please complete these forms so that we can provide the best possible care for you.

Today's Date: _____

About you

Name of patient: _____ Date of Birth: _____

I like to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Spouse's Name: _____

Special Interests or hobbies: _____

Which other family members do we see? _____

Whom can we thank for referring you? _____

Telephone Information

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Best time to call you and which #? _____

Email Address: _____

May we send you email courtesy reminders: Y / N

May we send you text message courtesy reminders? Y / N

May we send you email Newsletters and special announcements? Y / N

Nearest relative that's not living with you, or in case of emergency who we can call?

Name: _____ Phone number: _____

Account Registration

Head of Household:

Name: _____

Date of Birth: _____

SS #: _____

Employer: _____

Work phone #: _____

Relationship to patient: _____

Co-Head of Household:

Name: _____

Date of Birth: _____

SS #: _____

Employer: _____

Work Phone #: _____

Relationship to patient: _____

Dental Insurance if Applicable

Primary Insurance Co.
Name and address:

Ins. Co. phone #: _____

Employer Name: _____

Employer phone #: _____

Policy Holder/Subscriber Name (employee)

_____

Date of Birth: _____

Member Id#: _____

Group #: _____

Secondary Insurance Co.
Name and address:

Ins. Co. Phone#: _____

Employer Name: _____

Employer phone #: _____

Policy Holder/Subscriber Name (employee)

_____

Date of Birth: _____

Member Id#:_____

Group #: _____

In consideration of the services rendered to me, or my dependents, I am obligated to pay Dr. Scott Steedman in accordance with his credit terms and policies.

Signature _____ Date _____
(Parent, if patient is a minor)

For our clients that have dental insurance to help with a portion of their dental expenses, we will bill your insurance for you and accept payment directly from your insurance company to apply to your account with our office; **the patient is responsible for the full fee charged regardless of insurance benefits.** Each insurance company and policy has unique limitations and their own schedule of benefits, which is dependent on what your employer has purchased for you. 1% per month fee on balances over 90 days.

"SIGNATURE ON FILE"
(FOR ASSIGNED DENTAL CLAIMS)

ASSIGNMENT:
I AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST. A COPY OF THIS AUTHORIZATION AND ASSIGNMENT SHALL BE AS VALID AS THE ORIGINAL. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT REGARDLESS OF ANY THIRD PARTY BENEFIT.

SIGNATURE: _____ DATE: _____