Scott W.W. Steedman, DDS, MPH
515 Highway 9 NE Suite #101
Lake Stevens, WA 98258
Tel (425) 334-4087 fax (425) 397-0399
www.SmilesbySteedman.com

Welcome!
Thank you for selecting our dental healthcare team – we are pleased to welcome your child to our practice! To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us – we are happy to help!

Your child

Child's Name ____________________________________

Wishes to be called ________________ Sex F / M

Birthdate __________________ Age ____________

Child's Home Address _________________________________

City ________________________ State/Zip ______________

Phone ______________________

Whom may we thank for referring you?___________________

Person Responsible for scheduling?

Name ______________________________________

Relationship to patient _________________________

How can we best reach you?

O Cell O Email

O Work O Home

Time of Day ________________

Mother

O Stepmother O Guardian

Name ____

Home Phone _______________ Cell Phone _________________

Work Phone ________________ Ext. # ________

Email ____

Employer ______________________ Occupation ____________

SS # ___________________________ Birthdate ______________

Marital Status

O Single O Married O Other ____________

Father

O Stepfather O Guardian

Name ____

Home Phone _______________ Cell Phone ______________

Work Phone _____________________ Ext. # _______

Email ____

Employer ______________________ Occupation ____________

SS # ___________________________ Birthdate ______________

Marital Status

O Single O Married O Other ________

Responsible Party other than listed

Name ______________________________________

Relationship to patient _____________________________

Birthdate _______________ SS # _____________________

Employer __________________ Occupation ___________

Work Phone __________________ Ext. # _____________

Home Phone ______________ Cell Phone _____________

Address ____ City _________________________ State/Zip ___________________

Emergency Contact

Name ____ Phone Number ____________________________

Relation to Patient _____________________________

Dental Insurance Information

Primary Insurance

Name of Insured ______________________________

Relationship to patient _________________________

Insured's Birthdate ____________________________

Insurance ID # ________________________________

Employer ____________________________________

Occupation ___________________________________

Insurance Company Name and Address:

Insurance Co. Phone # _________________________

Group # _____________________________________

Secondary Insurance

Name of Insured ______________________________

Relationship to patient _________________________

Insured's Birthdate ____________________________

Insurance ID # ________________________________

Employer ____________________________________

Occupation ___________________________________

Insurance Company Name and Address:

Insurance Co. Phone # _________________________

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/ Guardian

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.

Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.
I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent/ Guardian Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.