# *The Smile Salon & Day Spa*

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## Patient Information

| | | | | |
|---|---|---|---|---|
| **Last Name:** | **First Name:** | | **Preferred Name:** | **Date of birth:** |
| **Address:** | **Apt #:** | **City:** | **Sate:** | **Zip Code:** |
| **Social Security Number:** | | **Home number:** | | **Cell number:** |
| **Email:** | | **Referred by:** | | |
| **Emergency contact:** | **Relationship to patient:** | | | **Cell number:** |

### Primary insurance information

| | | | | |
|---|---|---|---|---|
| **Last Name:** | **First Name:** | | **Relationship to Patient:** | **Date of birth:** |
| **Address:** | **Apt #:** | **City:** | **Sate:** | **Zip Code:** |
| **Social Security Number:** | | **Home number:** | | **Cell number:** |
| **Employer:** | | **Work number:** | | |
| **Name of insurance Co:** | | **ID number:** | | **Group number:** |

### Secondary insurance information

| | | | | |
|---|---|---|---|---|
| **Last Name:** | **First Name:** | | **Relationship to Patient:** | **Date of birth:** |
| **Address:** | **Apt #:** | **City:** | **Sate:** | **Zip Code:** |
| **Social Security Number:** | | **Home number:** | | **Cell number:** |
| **Employer:** | | **Work number:** | | |
| **Name of insurance Co:** | | **ID number:** | | **Group number:** |

Our office requires PAYMENT AT TIME OF SERVICE. Please refer to our Financial/Insurance Policy regarding those details. There is a $25 fee for all returned checks. Should attorney's fees be incurred in collecting on your account, you will be required to pay those fees.

**Note: We have a 24-hour reschedule/cancellation policy. Patient will be charged a $50 fee for no-show appointments.**

Signature _____ Date _____