



UNIVERSAL SMILES  
WHERE SMILES COME TO LIFE

Brad W. Griffin, DDS

**Welcome to Universal Smiles Dental Office!**

Thank you for selecting our dental office. To help us meet all of your dental health care needs, please complete this form as accurately as possible.

Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle \_\_\_\_\_ Preferred Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ DL # \_\_\_\_\_ Person filing out form: \_\_\_\_\_

Please circle: M F Marital Status: Single Married Divorced Student: Y N

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ EXT \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Responsible Party: Please fill out if different from above

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle \_\_\_\_\_ Preferred Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ DL # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Please circle: M F Marital Status: Single Married Divorced Student: Y N

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ EXT \_\_\_\_\_ Cell \_\_\_\_\_

Primary Dental Insurance

Name of Insured \_\_\_\_\_ Patient Relationship to insured \_\_\_\_\_

Insured Birth Date \_\_\_\_\_ Insured Social Security # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_ Group # \_\_\_\_\_ Secondary Dental \_\_\_\_\_

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[www.universal-smiles.com](http://www.universal-smiles.com)