WELCOME

The benefits of a happy, healthy smile are Immeasurable! Our goal is to help you reach and maintain excellent oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Are you a full time student? Yes/No Name of school _____ City _____

Name (last, first) _____ Age _____ Birthdate _____ ☐ Male ☐ Female

Home Address _____ City _____ ST _____ Zip _____ Phone _____

SS# _____ CA Driver's License# _____ E-mail: _____

Employer: _____ Work# _____ Ext. _____

Employer's Address _____ Pager/Other# _____/_____

Street City State Zip

Whom should we thank for **referring** you to our office? _____

Person Responsible for Account

Name (last, first) _____

Relationship of responsible party to patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian

If responsible party is other than patient, please complete the remainder of this section.

Home Address _____ City _____ ST _____ Zip _____ Phone _____

Business Address _____ City _____ ST _____ Zip _____ Phone _____

SS# _____ Employer _____ Occupation _____

CA Driver's License# _____

Spouse Information

Employer: _____

Name: _____ WK#: _____ Ext ____ SS#: _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

(Other than spouse) Name Relationship Phone

If you have dental and/or medical insurance please complete this section. Insurance policies are **contracts** between you and your insurance company. We are happy to assist you with your claim forms, and your efforts to get appropriate coverage. To avoid misunderstandings regarding health insurances, our professional services are charged directly to you and you are personally responsible for payment of fees.

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City, State, Zip: _____

Insurance Co. Phone #: _____

Group or plan #: _____ I.D. #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City, State, Zip: _____

Insurance Co. Phone #: _____

Group or plan #: _____ I.D. #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday ___/___/___ Insured's SS #: _____

Insured's Employer: _____

CONSENT: The undersigned herby authorizes the **Doctor and staff** to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by **Doctor** to make a thorough diagnosis of the patients's dental needs. I also authorize **Doctor** to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the **Doctor** and that I am still fully responsible for all dental fees. These **fees are due and payable** at the time services are rendered **unless** prior financial arrangements have been made. I also assign all insurance benefits to the **Doctor**. Any payments received by the **Doctor** from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Signature: _____ Date: _____

PATIENT & INSURANCE INFORMATION