

Patient Information

Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ___/___/___
 Home Address: _____ City: _____ State: ___ Zip: _____
 E-mail: _____ Home Phone: _____ Cell Phone: _____
 Social Security No: ___-___-___ Sex: Male Female Marital Status: Single Married Separated/Divorced
 Employer's Name: _____ Work Phone: _____ Occupation: _____
 Employer's Address : _____ City: _____ State: _____ Zip: _____
 Emergency Contact Person: Name: _____ Phone: _____ Relationship: _____
 How did you learn about our practice? Please check box.
 Friend Relative Dentist Phvsician Website Telephone Book Former Patient Other:

Responsible Party

(Parent's/Guardian's Information for Patients who are under 18)

Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ___/___/___
 Is the person listed above currently a patient in our office? Yes No Relationship to patient: _____
 Home Address: _____ City: _____ State: ___ Zip: _____
 E-mail: _____ Home Phone: _____ Cell Phone: _____
 Social Security No: ___-___-___ Sex: Male Female Marital Status: Single Married Separated/Divorced
 Employer's Name: _____ Work Phone: _____ Occupation: _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Information

Insured Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ___/___/___
 Insured Address: _____ City: _____ State: ___ Zip: _____
 Patient's Relationship to Insured: Self Spouse Parent _____ Insured Social Security No.: ___-___-___
 Employer: _____ Employer's Phone No.: _____
 Insurance Company: _____ Insurance Phone No.: _____
 Group No.: _____ Policy No.: _____ Effective Date: _____

Secondary Insurance Information

Insured Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ___/___/___
 Insured Address: _____ City: _____ State: ___ Zip: _____
 Patient's Relationship to Insured: Self Spouse Parent _____ Insured Social Security No.: ___-___-___
 Employer: _____ Employer's Phone No.: _____
 Insurance Company: _____ Insurance Phone No.: _____
 Group No.: _____ Policy No.: _____ Effective Date: _____

I hereby authorize payment directly to Anaheim Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and /or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistant and other medical personnel.

Signature of Patient

Signature of Responsible Party