Date_____

Name_____ Circle One: MR. MRS. MISS
First Last

Social Security #_____ Birthdate _____

Address_____ Home Phone (_____)_____

_____ Cell Phone (_____)_____

Employer/Job_____ Work Phone (_____)_____

Work Address _____

_____

Comments_____

Emergency Contact

Name_____ Relation _____ Phone (_____)_____

Insurance Information

Name of Insurance_____ Circle One: CASH / PPO / HMO / Medi-Cal

Policy Holder's Name (if not yourself)_____ Birthdate _____

Social Security #_____ Relation _____

Office Policies

How did you learn about this office?_____

Insurance Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for the total cost of my dental treatment in case my insurance does not pay, or only partially pays for the treatment. I also authorize the dental office to administer such medications and perform such diagnostic, radiographic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Name_____ Date _____ Signature _____

We pride ourselves in providing quality dental care to our patients in a punctual manner. Missed appointments and late cancellations cost our office money in time lost and other expenses. We, therefore, require a **48 hr.** in advance notice for appointment cancellations or there will be a **$50** charge per hour of time missed. We understand those rare times when an emergency situation may justify a late cancellation and we will, under our own discretion, dismiss the charge in such a case. We honor your time and we require that you do the same. By signing this form you acknowledge the legitimacy of this office policy and its enforcement.

Name_____ Signature _____