CAÑADA DENTAL

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle
Address_____
Street City State Zip
Home Ph # (___)_____Cell Ph # (___)_____Soc. Sec. #_____-____-_____
Drivers Lic. #_____ Birth Date _____ Age:_____ Sex: _____
If patient is a minor, give parent's/guardian's name_____
If patient is a full/part-time student, fill in school name_____
Emergency Contact _____Ph# (___) _____
Physicians Name_____ Ph# (___)_____
Email address: _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle Marital Status
Residence_____
Street City State Zip
Mailing Address_____
Street City State Zip
How long at this address_____ Home Ph # (___)_____Work Ph # (___)_____
Previous Address (if less than 3years) _____
Street City State Zip
Soc. Sec #_____-____-_____ Birth Date _____ Relationship to patient_____
Employer _____ Occupation _____ No. Years Employed_____
Employer Address_____

INSURANCE INFORMATION

Name of Insured_____ Insured Soc. Sec # _____-____-_____
Insurance Company_____ Group #_____
Insurance Co. Address_____ Ins. Ph # (___) _____
Is policy connected with your union? Yes_____ No _____Name of Union and #_____

Do you have dual coverage? Yes____ No____ If yes: Complete the secondary information:
Name of Insured_____ Relationship to insured _____
Insured Soc Sec # _____-____-_____Date of birth_____
Insurance Co._____ Group #_____
Insurance Co. Address_____ Ph # (____)_____
Insured's Employer_____ Ph # (____)_____