Alameda Dental

PATIENT INFORMATION

Registration

Patient Name _____ Birthdate _____ Gender _____

Minors: Legal Guardian Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____

Students: School _____ Grade _____

Minors: Parent Name(s) _____

Referred By _____

Financial

Do you currently have dental insurance coverage? Yes / No

If Dental Insurance, Subscriber Name _____ Birthdate _____

Insurance Company _____ Group Number _____

Employer _____ ID Number _____

Patient's Relationship to Insured? Self / Spouse / Child

Is There Secondary Dental Insurance? Yes / No
- If yes, please provide on additional sheet

Agreement

1. I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care.
2. I authorize release of information concerning my health, advice, and treatment to another dentist or physician.
3. I authorize release of information concerning my health, advice, and treatment for the purpose of evaluating and administrating claims for insurance benefits.
4. I authorize payment of insurance benefits, otherwise payable to me, directly to the dentist.
5. I understand that I am responsible for all cost of dental treatment, and that amount not covered by insurance is payable at the time of service.

Patient/Parent Signature _____ Date _____

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