

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Gender: _____ Family Status: _____ Date: _____
Last, First MI

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Preferred phone to call Home Work Cell Best time to call: Morning Afternoon Evening Any Time

Email address: _____ Can we send info to your email? Yes No

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____
Street Apartment #

City State Zip Code

Emergency Contact: _____ Relationship to patient _____ Phone _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____ Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ SSN _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Chief Complaint

What was the reason for today's visit? _____

Referral Information

Whom may we thank for referring you to our practice?

Another patient Dental Office Yellow Pages Newspaper School Work Dental insurance company

Web site Other _____

Name of person or office referring you to our practice: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Family History of any diseases:
_____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Stroke | Other: _____ |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Tumors | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Pregnancy
Due date: _____ | | <input type="checkbox"/> Venereal Disease | |

• Are you taking any medications? List of medications _____

• Have you been admitted to a hospital or needed emergency care during the past five years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Consent for Services

I authorize Rancho Del Rey Center for Periodontics and Dental Implants and my dentist(s) to release any and all medical or dental information for evaluation, treatment, and any anticipated care. The above information has my release to forward to my insurance carrier for purposes of claims, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the signature date until revoked in writing. I hereby authorize payment to the above named dentists of the group insurance benefits, otherwise payable to me, but not to exceed the charges submitted. I understand that I am financially responsible for any charges (including collection fees); and that I am responsible for knowledge of my insurance program and limitations. Interest accrues 90 day after services are rendered. I understand that I may request a copy of this form. I have read this authorization and understand its contents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party