Port Isabel Dental Associates

Patient Information:

Date ___________________

Name____

Mailing Address ____

____

Physical Address ____

____

Sex: ___M ___F Age_____ Birthdate_________________

__Single __Married __Separated __Widowed __Divorced

Have you ever been a patient of **Los Fresnos Dental Center**?
No________ Yes________ If "yes" when? ______________________

Occupation ____

Employer____

Employer Phone (_____)_______________________________

Spouse's Name ______________________________________

Birthdate _________________ SS#_____________________

Spouse's Employer____________________________________

Whom may we thank for referring you?____________________

____

Dental Insurance:

Who is responsible for this account?______________________

Relationship to patient_______________________________

Insurance Co_______________________________________

Group #____

Social Security # of Insured ___________________________

Is patient covered by additional insurance? __Yes __No

Subscriber's Name___________________________________

Birthdate____

Relationship to patient_______________________________

Insurance Co_______________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _________________________and assign directly to Port Isabel DENTAL ASSOCIATES all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

_________________________ ___________________
Relationship Date

Has any member of your immediate family a patient of our practice? ___No ___Yes If "yes," please list names:______________

____

Phone Numbers

Home (______)____________________ **Work** (______)____________________ **Cellular** (______)____________________

Best time to reach you______________________________ Email Address______________________________

Would you like for our office to send you courtesy appointment reminders via Email? _____Yes _____No

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name____ Relationship_____________________________

Home Phone (_______)____________________Work (______)____________________Cellular(_____)____________________

How Did You Hear About Our Office?

__Yellow Pages (Big Book) __Local Phone Book (Small Book) __Newspaper __Sign __Building/Location

__Patient -If so, please give us the name so that we may send thanks:______________________________

__Word of Mouth __Other:____

The information I have provided on all pages of my 'New Patient' paperwork is correct to the best of my knowledge.

Patient's **Signature**: ____________________________________ Date: ______________________

If patient is under the age of 18, signature of Parent or Legal Guardian:

Parent or Legal Guardian: ____________________________________ Date: