

Patient Information Sheet

Office: _____

Patient Information

Name: _____
 Address: _____ Apt #: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Home #: _____ Work #: _____
 Mobile #: _____ Texting OK? Yes No
 E-Mail Address: _____

How do you prefer we contact you?

Home Phone Work Phone Mobile Phone E-Mail

Responsible Party

Name: _____
 Address: _____ Apt #: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Home #: _____ Work #: _____
 Mobile #: _____ Texting OK? Yes No
 E-Mail Address: _____

How do you prefer we contact you?

Home Phone Work Phone Mobile Phone E-Mail

Employment Patient Responsible Party

Employer: _____
 Occupation: _____ How Long? _____
 Business Address: _____
 City: _____ State: _____ Zip: _____
 Business Phone: _____ Ext: _____

Emergency Contact

Name: _____
 Address: _____ Apt #: _____
 City: _____ State: _____ Zip: _____
 Home #: _____ Work #: _____
 Mobile #: _____
 Relationship to patient: _____
 Physician Name: _____ Phone #: _____

Patient Name: _____

Chart #: _____ Date: _____

Insurance Coverage (check one)

Denti-Cal HMO PPO Indemnity Other _____

Insured Party Information Only (if applicable)

Name: _____ Apt #: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Employer: _____ Union/Local: _____

Policy # /Group #: _____ Insurance ID #: _____

Primary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Secondary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insured's Name: _____ Insured's SSN#: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Union/Local: _____ Policy # / Group #: _____

How did you hear about us?

1-800-Dentist Flyer/Ad Insurance /Plan Referral: _____

Sign/Building Marketing Representative: _____

Yellow Pages Employer DDS Referral: _____

Family/Friend Website

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that West Coast Dental and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with West Coast Dental, or for other informational purposes related to my account or treatment ("Communication"). I also agree that West Coast Dental and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. West Coast Dental will not charge for a Communication, but my service provider may. I agree that West Coast Dental may monitor and record any telephone calls to assure the quality of its service or for other reasons.

Signature of Responsible Party (Parent or Legal Guardian if patient is a minor) _____

_____ Date

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comments

