Anaheim Hills Village Dentistry

Patient Information

PATIENT INFORMATION

Name _____
Last First
Address _____ Apt. #_____
City _____ Zip Code _____
How long at this address? _____
Social Security # _____
Birth Date _____
Home # ( ) _____
Daytime Contact # ( ) _____
Cell# ( )_____
E-mail: _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First
Address _____ Apt. #_____
City _____ Zip Code _____
How long at this address? _____
Phone # ( ) _____ Cell# _____
Social Security # _____
Relationship to Patient _____
Birth Date _____

EMPLOYMENT

Occupation _____
Employer _____
How long? _____
Business Address _____
City _____ Zip Code _____
Business Phone # _____ Ext. # _____

STUDENT STATUS

Full-time Part-time
School name _____
Address _____
City _____ Zip Code _____
Phone # ( ) _____
Please circle one:
Freshman Sophomore Junior Senior

INSURANCE

Primary Insurance Company
Name_____
Address_____
City, Zip _____
Insurance Co. Phone # _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birth date _____

Secondary Insurance Company
Name_____
Address_____
City, Zip _____
Insurance Co. Phone # _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birth date _____

GETTING TO KNOW YOU

How did you hear about us?
___ Friend/Family Who may we thank for referring you?
Name: _____
___ Phonebook
___ Flyer/Ad
___ Sign/Drove by
___ Insurance
___ Other: _____

How would you like us to contact you to confirm appointments?
(Check all that apply)
____ Cell Phone
____ Home Phone
____ Daytime Contact Phone
____ E-mail
Person to contact in case of Emergency:

Last First
Address: _____ Apt. # _____
City _____ Zip _____
Tel # _____

1. I hereby certify that the above information is accurate and will be relied upon for providing dental services and making payment arrangements. **I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.**
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to **Anaheim Hills Village Dentistry** of 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.

Signature of responsible party or patient Date