



Kelly A. Elward, DDS

WELCOME

100 Doctors Park Drive, Santa Rosa, CA 95405, 707/539-4646

Please take a few minutes to complete the following confidential information.

If you have any questions we'll be glad to help you.

Patient Information

Date _____	Social Security # _____	Birth Date _____
Last Name _____	First Name _____	Home Phone _____
Address _____		
City _____	State _____	Zip _____
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age _____
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorce
<input type="checkbox"/> Widowed	E-Mail Address _____	
Cell Phone _____		Where can you be reached during the day? _____
_____ Home	_____ Work	_____ Cell
_____ E-mail	Patient Employed by _____	
Occupation _____		Business Address _____
Business Phone _____		Whom may we thank for referring you? _____
Person to contact in case of an emergency _____		Phone _____
Closest relative not living with you _____		Phone _____
Address _____		

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company

And assign directly to Dr Elward all 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 for myself and/or minor children. 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 my insurance submissions whether manual or electronic.

Date _____ Signature _____

Primary Dental Insurance

Employee (Subscriber) _____		
Insurance Company _____	Group # _____	
Employer _____		
Business Address _____	Phone _____	
Occupation _____		
Employee date of birth _____	Social Security # _____	Date employed _____