PATIENT INFORMATION

Anaheim Hills Village Dentistry

Anaheim Hills Village Dentistry

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 # (_____) _____

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

INSURANCE

Primary Insurance Company

Name _____

Address _____

City _____ Zip Code _____

Insurance Co. Phone # _____

Employer _____

Union/Local _____ Group # _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birth Date _____

Secondary Insurance Company

Name _____

Address _____

City _____ Zip Code _____

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 ☐ Sign/Drove by ☐ Internet

☐ Flyer/Ad ☐ Insurance ☐ Website

☐ Other: _____

How would you like us to contact you to confirm appointments?
(Check all that apply)

☐ Cell Phone ☐ Daytime Contact Phone

☐ Home Phone ☐ E-mail

Person to contact in case of Emergency:

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip Code _____

Tel # (Not your own, please) _____

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 patient or responsible party Date