Dental Care
OF LA VERNE

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip Code _____

How long at this address? _____

Phone # ( ) _____

Social Security # _____

Age _____ Birth Date _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip Code _____

How long at this address? _____

Phone # ( ) _____

Social Security # _____

Relationship to Patient _____

Age _____ Birth Date _____

EMPLOYMENT

Occupation _____

Employer _____

How long? _____

Business Address _____

City _____ Zip Code _____

Business Phone # ( ) _____ Ext.# _____

Verified By _____ **Date** _____
(Office use only)

CREDIT (FOR MONTHLY PAYMENTS)

Own _____ Rent _____ How Long? _____

(If less than 1 year) _____

Previous Address _____

How Long? _____

Credit Card Name _____ # _____

Bank _____

Car Owned: Yes ___ No ___ Type _____

Monthly Income _____

Driver's License # _____

REFERENCES

Name _____
Last First

Address _____ City _____ Zip Code _____

Phone # ( ) _____

Name _____
Last First

Address _____ City _____ Zip Code _____

Phone # ( ) _____

Spouse Name _____
Last First

Spouse work # ( ) _____

INSURANCE (IF MEDI-CAL "SKIP")

Primary Insurance Company

Name _____

Address _____

City, Zip _____

Insurance Co. Phone # _____

Employer _____

Union / Local _____ Group # _____

Insured's Name _____

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

INSURANCE

Secondary Insurance Company

Name _____

Address _____

City, Zip _____

Insurance Co. Phone # _____

Employer _____

Union / Local _____ Group # _____

Insured's Name _____

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

MANAGED CARE PLAN (HMO)

Plan Name _____ Group # _____ Plan # _____

Employer _____

Insured's Name _____

Social Security # _____

GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office?:

YES __ NO __ Please list names & relationship (son, daughter, husband) below:

1: _____ 2: _____

3: _____ 4: _____

How did you hear about us? ☐ Friend/Family ☐ Flyer/Ad ☐ TV

☐ Sign/Drove By ☐ Insurance ☐ Other _____

I'd like information in Spanish: YES _____ NO _____

Person to contact for Emergency:

_____
Last First

Address _____

City _____ Zip _____ Tel # ( ) _____

Physician Name _____ Tel # ( ) _____

1. I hereby certify that the above information is accurate and will 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 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 Dental Care of La Verne of the group 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.

claims.

_____
Signature of responsible party or patient (Parent if patient is a minor) Date