Tell Us About Yourself

Date: _____

Name: _____
First Middle Last

How did you hear about our office? _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____
City/State/Zip Code

Home Phone: _____ Cell/Pager: _____
Work Phone: _____
Email Address: _____

Employer Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____ Cell/Pager: _____
Work Phone: _____

Person Financially Responsible for Account (Print Name): _____
Social Security Number: _____ Signatures: _____

DENTAL INSURANCE INFORMATION

Subscriber _____ Social Security #/Member ID# _____
Date of Birth _____ Patient Relationship to Insured _____
Employer _____ Insurance Company _____
Insurance Address _____
Insurance Co. Phone # _____

I authorize the release of any medical information to insurance companies or for legal documentation to process claims. This authorization will remain in force as long as I am a patient at Sanchez Dental Associates.

Signed _____ Date _____
(Patient or Guardian)

Great Teeth Better Life
SANCHEZ DENTAL ASSOCIATES