Eldorado Dental- Adult

PATIENT NAME: _____ **PREFERRED NAME:** _____
◯ **MALE** ◯ **FEMALE** ◯ **MARRIED** ◯ **SINGLE** ◯ **OTHER** _____
HOME ADDRESS: _____ **CITY:** _____ **ZIP:** _____
PHONE (HOME): _____ **(WORK):** _____ **EXT** _____ **(CELL):** _____
SOCIAL SECURITY #: _____ **BIRTH DATE:** _____
DRIVER'S LICENSE # / STATE _____ **EMPLOYER NAME:** _____
E-MAIL ADDRESS: _____

Please list other members of your immediate family who are patients in our office:
_____

Referral Information

Can we thank someone for referring you? Please circle one!
Family member or friend: _____, insurance website, dental website, yellow pages
Other: _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

Insurance Information

Name of policy holder: _____ Policy holder's DOB: _____
Policy Holder's Social Security # or insurance ID # _____ Group # _____
Patient's relationship to policy holder (check one): ◯ Self ◯ Spouse ◯ Child ◯ Other _____
Dental insurance company name: _____ Phone #: _____

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. Every effort will be made to help me with my insurance, but I understand my insurance company may not pay as expected; I will be fully responsible for remaining amount owed. **DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees/attorney fees.**

I hereby authorize payment directly to Eldorado Dental, Tony Reyes DDS, from group insurance benefits otherwise payable to me. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian_____

Date: _____