

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: _____