

# ***SANCHEZ DENTAL ASSOCIATES***

## **PATIENT INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_

(Last)

(First)

(Mi)

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Employer Name \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Pager/Cell. # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Extension \_\_\_\_\_

Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

For notification of specials,( i.e. Zoom whitening, products, etc) new practice information, and appointment notification.

How did you hear about our office?

\_\_\_\_\_

## **IN CASE OF EMERGENCY/RELATED PARTY INFORMATION**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Pager/Cell. # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Extension \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Pager/Cell. # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Extension \_\_\_\_\_

Do you have any related party in our practice? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Person responsible for account (Please Print) \_\_\_\_\_

Social Security # \_\_\_\_\_ Signature \_\_\_\_\_

## **INSURANCE INFORMATION**

Person Insured Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Patient relation to insured \_\_\_\_\_

Employer \_\_\_\_\_ Insurance \_\_\_\_\_

Company \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Co. Phone #** \_\_\_\_\_ **Date of Eligibility** \_\_\_\_\_

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.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# ***ACQUAINTANCE FORM***