DENTALZONE
MOUNTAIN VIEW

CONFIDENTIAL PATIENT INFORMATION

The information requested below will allow us to correctly establish and/or update your account. We appreciate your help in making this information as accurate and complete as possible. (PLEASE PRINT)

PATIENT INFORMATION

Name: _____ Nickname: _____ Birthdate: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Email: _____

( ) Male ( ) Female ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated

If you are a full time student, name of school _____

Home #: _____ Cell #: _____ Work #: _____

RESPONSIBLE PARTY INFORMATION

Name: If the same as the patient, write self _____ Birthdate: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

( ) Male ( ) Female ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Do you have Dental Insurance? ( ) No ( ) Yes (If Yes, please complete the following information)

	Primary Insurance	*Secondary Insurance*
Person Policy Issued to:		
Employed By:		
Occupation:		
Social Security or ID #:		
Date Of Birth:		
Name of Insurance Co.:		
Relationship to Patient:	( ) self, ( )spouse, ( )parent, ( ) other	( ) self, ( )spouse, ( )parent, ( ) other

Name of Medical Insurance Carrier: _____ *PPO ( ) HMO ( )*

We need the above information so that we can help you obtain the dental insurance benefits you are eligible for. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

WHOM MAY WE THANK FOR REFERRING YOU?

Name of the person we can thank: _____

Other – Please Specify: _____

AGREEMENT TO PAY

I understand that I am responsible for payment of services rendered and also am responsible for paying any co-payment and deductibles not covered by my insurance. I hereby authorize payment directly to Dental Zone. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

RESCHEDULE / CANCELLATION APPOINTMENT

If you are unable to keep your scheduled appointment, kindly give us 48 hrs. notice. Otherwise we reserve the right to charge $50.00 for time reserved.

SIGNATURE PATIENT / GUARDIAN: _____ DATE: _____

I consent to Dental Zone using my cell phone # to ***CALL / TEXT*** regarding appointments and to call regarding treatment, insurance, and my account

I understand that I can withdraw my consent at any time. My cell phone is ( ) same as above or _____ ( ) Initial