WELCOME...

To Bay Area Dental Surgery Center

PATIENT INFORMATION

Patient Name: _____ D.O.B.: _____ MR# _____
Office Use Only

Patient Social Security #: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Status: ☐ Minor ☐ Single ☐ Married **Referred By:** _____

RESPONSIBLE PARTY

Name: _____

Relationship to Patient: _____ D.O.B.: _____

Driver's License/ ID #: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Subscriber ID#: _____

Subscriber Name: _____ Subscriber D.O.B.: _____

Employer: _____ Occupation: _____

Secondary Insurance Carrier: _____ Subscriber ID#: _____

Employer: _____ Occupation: _____

CONTACT INFORMATION

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

Email Address: _____

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

EMERGENCY CONTACT: Name: _____ **Phone:** _____

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/ or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor/ doctor's group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of Patient/ Parent/ Legal Guardian Date