

UKIAH FAMILY DENTISTRY

Last Name: _____ First Name: _____ Middle Name: _____

Name you go by: _____ Sex: Male ___ Female ___ Other _____ DOB: ____/____/____

Mailing Address: _____ City: _____ State: ___ Zip: _____

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

Employer Name: _____ May we call work? Yes ___ No ___

Email: _____ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

How did you hear about us? _____

Emergency contact: _____ Phone: _____ Preferred Pharmacy: _____

All new patient/account information is verified with a driver's license or state issued ID. _____

As a courtesy we provide appointment reminders.

Choose **ONE** option for appointment reminder: Home ___ Cell ___ Work ___

Do you wish to receive a **TEXT** before your appointment? Yes ___ No ___

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

PRIMARY DENTAL INSURANCE COVERAGE:

Policyholder/Subscriber's Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Employer Name: _____

Employer Address: _____

DOB: ____ - ____ - ____ ID# _____ OR SSN: ____ - ____ - ____

Group#: _____ Insurance Company Phone: _____

Insurance Company Name: _____

Please give card to staff or supply address: _____

SECONDARY DENTAL INSURANCE COVERAGE:

Policyholder/Subscriber's Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Employer Name: _____

Employer Address: _____

DOB: ____ - ____ - ____ ID# _____ OR SSN: ____ - ____ - ____

Group#: _____ Insurance Company Phone: _____

Insurance Company Name: _____

Please give card to staff or supply address: _____

As a courtesy, we will submit your dental insurance claim for you. However, we cannot accept responsibility for collecting your insurance payment or for negotiating a settlement for payment. All account balances are the responsibility of the account holder.

Signature of Patient/Guardian: _____ Date: _____