Patient Information Sheet

Office: _____

Patient Information

Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Mobile #: _____ **Texting OK?** ☐Yes ☐No

E-Mail Address: _____

How do you prefer we contact you?

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Responsible Party

Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Mobile #: _____ **Texting OK?** ☐Yes ☐No

E-Mail Address: _____

How do you prefer we contact you?

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Employment ☐ Patient ☐ Responsible Party

Employer: _____

Occupation: _____ How Long? _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____ Ext: _____

Emergency Contact

Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Mobile #: _____

Relationship to patient: _____

Physician Name: _____ Phone #: _____

Patient Name: _____

Chart #: _____ Date: _____

Insurance Coverage (check one)

☐ Denti-Cal ☐ HMO ☐ PPO ☐ Indemnity ☐ Other _____

Insured Party Information Only (if applicable)

Name: _____ Apt #: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Employer: _____ Union/Local: _____

Policy # /Group #: _____ Insurance ID #: _____

Primary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Secondary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insured's Name: _____ Insured's SSN#: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Union/Local: _____ Policy # / Group #: _____

How did you hear about us?

☐ 1-800-Dentist ☐ Flyer/Ad ☐ Insurance /Plan Referral: _____

☐ Sign/Building ☐ Marketing Representative: _____

☐ Yellow Pages ☐ Employer ☐ DDS Referral: _____

☐ Family/Friend ☐ Website ☐

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that West Coast Dental and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with West Coast Dental, or for other informational purposes related to my account or treatment("Communication"). I also agree that West Coast Dental and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. West Coast Dental will not charge for a Communication, but my service provider may. I agree that West Coast Dental may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_____ _____

Signature of Responsible Party (Parent or Legal Guardian if patient is a minor) Date

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comments

REV.JUNE2020

West Coast Dental Services, Inc.