

Patient Information Sheet

Office: _____

Patient Information

Language: English Spanish Gender: Female Male
 Marital Status: Single Married Divorce Widowed Other
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Home #: _____ Work #: _____
 Cell #: _____ Texting OK? Yes No
 E-Mail Address: _____

Preferred method of communication

Home Phone Work Phone Mobile Phone Email

Responsible Party

Relationship to patient: Self Guardian/Parent Spouse Other
 Gender: Female Male
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Home #: _____ Work #: _____
 Cell #: _____ Texting OK? Yes No
 E-Mail Address: _____

Employer Information

Employment Status: Employed Student Retired Unemployed
 Employer/School Name: _____
 Occupation: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ How long? Year(s) Month(s)

Emergency Contact

Relationship to patient: Responsible Party Other
 Gender: Female Male
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home #: _____ Work #: _____
 Cell #: _____
 Physician Name _____ Phone #: _____

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. I authorize to receive information & alerts from West Coast Dental Services, Inc. via text messages. I understand this program is completely voluntary and that text messaging rates & fees may apply as determined by my cellular provider. West Coast Dental Services, Inc. is in no way responsible for any fees charged to me by my cellular provider. If at any time I wish to discontinue receiving text messages from West Coast Dental Services, Inc. I must notify the office in writing to withdraw from the text program.

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

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

Date	Signature	Comments

Patient Name: _____

Chart # _____ Date: _____

Primary Insurance Information

Insurance Type: No Insurance HMO PPO/Indemnity Denti-Cal
 Plan Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____
 Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: Self Responsible Party Spouse Other
 Gender: Female Male
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Employer: _____

Secondary Insurance Information

Insurance Type: No Insurance HMO PPO/Indemnity Denti-Cal
 Plan Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____
 Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: Self Responsible Party Spouse Other
 Gender: Female Male
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 SSN #: _____ Date of Birth: _____
 Employer: _____

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 Other _____

