Padre
DENTAL GROUP
Kaenel & Kaenel Dental Corporation
WWW.PADREDENTAL.COM

WELCOME

PATIENT INFORMATION:

First Name ________________________ MI ____ Last Name _______________________
Preferred Name ______________________________
Address ____
City ____ State _____ Zip Code _________
Date of Birth ____________________ Social Security # _________________________
Occupation _____________________ Employer _______________________________
Marital Status ___________________ Spouse's Name ___________________________

Whom may we thank for your referral to our office?_________________________________

PHONE NUMBERS AND CONTACT INFO:

For appointment reminders, would you prefer: ☐ text ☐ email ☐ phone call

Home Phone _______________ Cell _________________ Work ___________________
Email ____

EMERGENCY CONTACT:

Name of someone not in your household / Relationship to patient ____________________
Contact's home number ________________________ Work number _________________

PATIENT AGGREEMENT:

I have received a copy of *The Facts About Fillings* booklet approved by the California Dental Board. I will have the opportunity to read and discuss the information with my dentist prior to the placement of further dental restorative work.

The information that I have given today is true and correct, to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medications or medical condition. I authorize Padre Dental Group to perform any necessary dental services such as x-rays, study models, photographs or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize Padre Dental Group to perform any and all forms of treatment with my informed consent.

INSURANCE AND FINANCIAL POLICY:

I authorize direct payment of group insurance benefits, otherwise payable to me, to Padre Dental Group. As a courtesy to our patients who have dental insurance, we will be happy to file your claim. Your deductible and co-payment is due on the day of service. We will estimate these amounts for you using the information provided by your plan. Your insurance company may not pay their full portion as payment is affected by eligibility, policy provisions and possible charges from other offices. You are responsible for all treatment charges not paid by your insurance. I grant Padre Dental Group the right to release my dental records to a third party payor or other healthcare professional involved in my care.

Your appointment time has been reserved just for you. If you cannot keep your appointment, we ask that you give Padre Dental Group a two (2) business day notice of cancellation. We reserve the right to charge a fee for missed or broken appointments.

Patient or Guardian Signature__________________________________ **Date** ____/____/____