 **WELCOME**

**PATIENT INFORMATION:**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find our office? Friend\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Yelp Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE NUMBERS AND CONTACT INFO:**

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

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Name / Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact’s phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT AGGREEMENT:** I have received a copy of *The Facts About Fillings* booklet approved by the California Dental Board or choose to review it online at www.padredental.com. I will have the opportunity to 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. Your deductible, co-payment or patient portion is due at the start of service. We will estimate these amounts for you by using the ***information provided by your plan,*** if you are insured. 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. Any account more than 90 days past due will be subject to collections and a 33% charge added to the account to offset collections fees.

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 $25 fee for missed or broken appointments.

**Patient or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_**