

# cabrillo dental

FAMILY AND COSMETIC DENTISTRY

Everything you need for a healthy smile

## PATIENT ACKNOWLEDGEMENTS

PLEASE FILL OUT THIS FORM COMPLETELY

### 1 About You

Name \_\_\_\_\_

Preferred Name \_\_\_\_\_  Male  Female

Single  Married  Divorced  Widowed  Separated

Birthdate / / Age \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Fax # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Other family seen by us? \_\_\_\_\_

Last visit date \_\_\_\_\_

Employer \_\_\_\_\_

Employer # \_\_\_\_\_ How long there? \_\_\_\_\_

### 2 Account Info

Personal Responsible for Account

Name \_\_\_\_\_ Relation \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Fax # \_\_\_\_\_

Email \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 3 Spouse Information

Name \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Birthdate / /

Email \_\_\_\_\_

### 4 Insurance

Provider Insurance \_\_\_\_\_

Provider Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Ph # \_\_\_\_\_

#### SECONDARY INSURANCE

Provider Insurance \_\_\_\_\_

Provider Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Ph # \_\_\_\_\_