PATIENT INFORMATION

Welcome! We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. This information is necessary for our files and will be considered ***confidential***. If you have questions, we will be glad to help you. We look forward to working with you and maintaining your dental health!

DENTALCARE
ROLAND L. ELAZEGUI, DMD, INC.

Patient's Name: _____ SSN: _____
First Last Middle Initial

I prefer to be called _____ Age _____ Date of Birth _____ ☐M / ☐F

If patient is a minor, give name of parent of legal guardian _____ Relationship _____

Residence Address _____
Street *City* *Zip Code*

Marital Status: ☐Married ☐Partnered ☐Single ☐Divorced ☐Separated ☐Widowed

Cell phone: (_____) _____-_____ Home Phone: (_____) _____ Email: _____

What is your preferred method of contact? _____ Consent to receive email and text messages _____
Patient Initials

Employed by _____ Occupation _____Work Phone (_____) _____-_____

If you are a college student, school you attend _____ ☐Full Time ☐Part Time

Whom may we thank for referring you? _____

Emergency Contact Name: _____ Relationship: _____

Complete Address _____
Street *City* *Zip Code*

Cell phone (_____) _____-_____ Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

PRIMARY INSURANCE INFORMATION

Person responsible for this account: _____ Relationship _____

Address _____
Street *City* *Zip Code*

Name of insurance company (primary insurance) _____

_____
Insured Person's Name *Date of Birth* *Relationship* *Social Security No.*

Name of Group Dental Plan *Group No.* *Plan No.* *Name of Union* *Local*

ADDITIONAL INSURANCE INFORMATION

Name of insurance company (secondary insurance) _____

_____
Insured Person's Name *Date of Birth* *Relationship* *Social Security No.*

Name of Group Dental Plan *Group No.* *Plan No.* *Name of Union* *Local*

STATEMENT OF CONSENT: FINANCIAL RESPONSIBILITY AND INFORMATION RELEASE

1. I understand that I am expected to check with my insurance company regarding covered benefits.
2. I authorize the use of this signature on all insurance submissions.
3. I authorize the dentist to release all information necessary to secure the payment of benefits.
4. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.
5. I authorize my insurance company to make payments directly to Roland L. Elazegui, DMD, Inc.

Signature _____ ***Date*** _____