New Patient Information

Rockridge Smiles
The Peterson Chan Dental Group

Patient's Name: ______________________________
Home Address: ______________________________
____
City:________________Zip:__________
Employer or School: __________________________
Address:____________________________________
____

Birth Date: ______________Gender______
Soc. Sec. #:__________________________
Home Phone # :________________________
Drivers License: _______________________
Cell Phone:___________________________
Work Phone:__________________________
Occupation :__________________________
Marital Status: ________________________

Referred by:______________________________________Emergency Contact:____________________
E-mail Address:____

Insurance Information

Primary Carrier:

Policy holder: ______________________________
Relation to Patient: ❑ Self ❑ Spouse ❑ Parent
Employer: ________________________________
Business Address: ___________________________
____
INS I.D. #: _________________________________

Insurance Co.: _______________________
Address: ____________________________
____
Telephone #:_________________________
Policy #: ____________________________
Birth Date:___________________________

Secondary Carrier: (If applicable)

Ins Information: ____
____

Note to patients with insurance: WE ARE IN-NETWORK PROVIDERS FOR DELTA DENTAL ONLY.

We are happy to process any insurance claim as a service to you. Please keep in mind that any insurance reimbursements quoted are only estimates and we cannot predict what the insurance company will do, and you are responsible for the fees in their entirety. The insurance plan is purchased by you and/or your employer and we ask that you understand all the provisions of your policy. ______ (initials)

Signature on file for claims
I hereby authorize the direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.

X________________________________

Note to all patients:
We request that all services are paid for at the time received, including copayments. If your treatment requires extended visits or larger treatment plans, a payment schedule may be arranged.
Please allow a 48-hour cancellation courtesy for all appointments. Without sufficient notice a fee may be charged.

Patient's Signature: ______________________________ Date: ______________________________