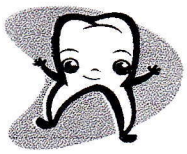

ESPECIALIDADES
DENTALES
GENERAL DENTISTRY
4008 N 33RD AVE
PHOENIX, AZ 85017-4510

Chart # _____ **Patient Information Sheet** Date _____

First Name: _____ Middle Int. _____ Last Name: _____
Date of Birth: _____/_____/_____ Sex: (M) (F)
Home Address: _____ Apt # _____ City: _____
State: _____ Zip: _____
Home Phone #: (___) _____ Cell Phone #:(____)_____
E-Mail address:_____ DL/ ID # _____ State: _____
Social Security #: _____-_____-_____
Employer: _____ Position: _____
How Long: _____ Employer Address: _____
City: _____ State: _____ Zip: _____
Work Phone Number: (_____) _____ Ext.:_____
In Case of Emergency_____ Phone # (___)_____ Cell Phone: _____
Relationship: _____

Responsible Party

First Name: _____ Middle Int. _____ Last Name:_____
Date of Birth: _____/_____/_____ Sex : (M) (F)
Home Phone #:(_____)_____ Cell Phone #: (____) _____
E-Mail address:_____ Social Security #: _____-_____-_____
Employer: _____ Position: _____ How Long: _____
Employer Address: _____
Work Phone Number: ( ) _____Ext.:_____
City: _____ State: _____ Zip: _____Relationship to Patient: _____
How do you intend to pay? ___ Cash ___ Credit___ _ Insurance___ _ A.C.C.C.H.S___ _ Other _____

Personal References

First Name: _____ Last Name:_____
Relationship: _____ Home Phone Number: (_____) _____
Home Address: _____Apt # _____
City: _____ State: _____ Zip: _____

Primary Insurance Information

Insured First Name: _____ Last Name: _____
Date of Birth: _____/_____/_____
Insured Address: _____
Patient's relationship to Insured (Circle): Self—Spouse—Child—Parent--- Sex: (M) (F)
Insured Social Security Number: _____-_____-_____
Employer_____ Employer's Phone Number (_____) _____
Insurance Company: _____ Insurance Co. Address: _____
Effective Date _____ Group #: _____ Policy or ID #: _____
Phone Number of Insurance Co.: (_____) _____

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.

Signature of Patient _____

Signature of Responsible Party_____