REDONDO BEACH DENTAL ARTS

YOUR INFORMATION

NAME: _____
FIRST M.I. LAST

NICKNAME: _____ GENDER: M F EMAIL: _____

BIRTHDATE: _____ AGE: _____

_____
STREET CITY STATE ZIP CODE

SSN: _____ HOME PHONE _____ CELL PHONE _____

REFERRED BY: _____ EMPLOYER: _____ HOW LONG: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT NAME _____ PHONE: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATION: _____

BILLING ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ WORK PHONE: _____ CELL PHONE: _____

CREDIT CARD: _____ CC EXP. DT: _____ CC SEC. CDE: _____

INIT: _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance carrier.

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

CARRIER: _____

ADDRESS: _____

_____
CITY STATE ZIP CODE

PHONE _____ FAX: _____

INSURED ID#: _____

GROUP, POLICY #: _____

INSURED'S NAME: _____

RELATION: _____ DOB: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

SECONDARY DENTAL INSURANCE:

CARRIER: _____

ADDRESS: _____

_____
CITY STATE ZIP CODE

PHONE _____ FAX: _____

INSURED ID#: _____

GROUP, POLICY #: _____

INSURED'S NAME: _____

RELATION: _____ DOB: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____