1620 ALPINE BLVD., SUITE 121, ALPINE, CA 91901
ALPINEDENTISTRY.COM

Today's Date_________________ Email Address_____________________________

Name____Nickname _____________________Are you a Veteran? Y ____ N______
Last First

Birthdate________/_______/_________ Age_______ SSN________________________ Driver's Lic #__________________State _______

Mailing
Address____
Street City State Zip

Home Phone (______)_________________________ Cell (______)_______________________ Work (______)__________________________

Whom may we thank for referring you?________________________________ Other Family members seen here_____________________________

Employer____ Occupation___________________________________ Years__________

Employer Address____ Employer Phone (_____)___________________________________

Relative not living with you_______________________________________ Phone (_____)___________________ Relation__________________

SPOUSE INFORMATION

Name____ Birthdate_______________________ SS#____________________________

Spouse Employer ____ Phone (_____)____

DENTAL INSURANCE INFORMATION

Insurance Co Name____ Phone (_____)__________________ Group #__________________

Insurance Co Address ____
Street / PO Box City State Zip

Insured's Name____________________________________ Insured's ID#___________________________ Insured's Birthdate____/____/______

Insured's Employer Name & Address____

SECONDARY DENTAL INSURANCE, IF ANY:

Insurance Co. Name____ Phone (_____)___________________ Group #_________________

Insurance Co. Address____
Street / PO Box City State Zip

Insured's Name ___________________________________ Insured's ID #____________________________ Insured's Birthdate ____/____/______

Insured's Employer Name & Address____

I assign Alpine Dentistry all insurance benefits. I understand that I am responsible for payment of services rendered, and deductible, and copayment that my insurance does not cover at the time of the procedure. A copy of the Dental Board of California's Dental Materials Fact Sheet and the Notice of Privacy Practices as described by HIPAA are available for my review. I understand that I may be charged for appointment time that is failed or cancelled without 24-hour notification. All accounts over 60 days may be subject to finance charge.

Do we have permission to call and leave you a message regarding dental treatment on your home or cell number? Y______ N______

Patient Signature/Personal Representative:____ **Date:**____________________________