ALPINE DENTISTRY

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

Today's Date_____ Email Address_____

Name _____ Nickname_____ Male_____ Female_____
Last First

Birthdate_____/_____/_____ Age_____ School:_____

Child's Mailing
Address_____
Street City State Zip

Home Phone (_____)_____

Whom may we thank for referring you?_____ Other Family members seen here_____

PARENT INFORMATION

Mother's Name_____ Birthdate_____ SS#_____

Mother's Address if different:_____Home Phone (_____)_____ Cell (_____)_____

Mother's Employer_____ Work Phone (_____) _____

Father's Name_____Birthdate_____SS#_____

Father's Address if different:_____Home Phone (_____)_____Cell (_____)_____

Father's Employer_____ Work Phone (_____) _____

Parent's Marital Status: _____ Married _____ Divorced _____ Separated _____ Widowed _____ Remarried _____ Single _____

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.

Parent/Guardian/Personal Representative Signature:_____ Date:_____