

Welcome to California Dentistry & Braces
"Our business is your Smile!"

1. Patient's Name _____
2. Responsible Party Self Spouse _____ Other _____
3. Address _____ City _____ Zip _____
4. Rent Own How Long: _____
5. Home Phone # () _____ 6. Work Phone # () _____ 7. Sex: M F
8. Marital Status: Single Married Divorced Separated Widowed
9. Social Security Number _____ - _____ - _____ 10. Birthdate: _____ / _____ / _____
11. Employer _____ 12. Occupation _____
13. Employer Address _____ How long _____
14. In case of Emergency, who would be notified?
1. _____ Tel: () _____ Relationship _____
2. _____ Tel: () _____ Relationship _____
15. Whom may we thank for your referral? Sign Newspaper T.V. Flyer
- Friend _____ Family Member _____ Other _____
16. Please provide email address: _____

If Patient is Married, Complete this Portion

Name of Spouse _____ Occupation _____ SSN _____

Employer _____ Business Phone # () _____

Employer Address _____ City _____ Zip _____

If Patient is a Minor (Under 18), Complete this Portion

Legal Guardian _____ Occupation _____ SSN _____

Employer _____ Business Phone # () _____

Employer Address _____ City _____ Zip _____

Please Complete The Following Financial Information

Insurance Co. _____ Name of Insured _____ Policy # _____

If Union, Name _____ Local Number _____ Group # _____

Secondary Insurance _____ Name of Insured _____ Policy # _____

If Union, Name _____ Local Number _____ Group # _____

CONSENT

Please read thoroughly before signing.

I HAVE FILLED OUT THIS QUESTIONNAIRE ACCURATELY. I HAVE INFORMED YOU OF ALL MEDICAL PROBLEMS OF WHICH I AM AWARE.

I understand that all bridges, crowns, dentures, and partials are custom work and the entire charge is incurred once the procedure is begun. I also understand that any remake of these procedures due to my failure to have them completed in a normal length of time may result in additional charges.

I further realize that the financial arrangements in regards to insurance are estimates based on normal ethical dental practices and available information concerning my insurance coverage and that I am ultimately responsible for the bill.

I also agree to keep all of my appointments and acknowledge I may be charged for failure to do so without a 24-hour notice.

I have been informed of all risks involved in my dental treatment and anesthesia, and am giving consent to have these services performed.

It is understood that any dentist performing work is an independent contractor.

By signing below I understand that you may request a credit report on me and any additional applicants.

I agree to pay for all dental services rendered.

Date _____

Signature of Patient
(Patient or Guardian, If Minor)