Encinitas Dental Art

1445 Encinitas Blvd • Encinitas, CA 92024 (760)942-7272

New Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-____* (Zip Code)

How did you hear about our office? *

◯ Website ◯ Patient Referral ◯ Dr. Referral ◯ Drive By/Walk In

Emergency Contact Information:
Please list name, phone number and relationship: *

_____

_____

Pharmacy Information:
Please list the name of the pharmacy with address and phone number. *

_____

_____

We like to get to know our patients on a personal level. Knowing what is important to you (family, hobbies, work, etc.) helps us link your dental needs to your lifestyle and better serve you. With that said, please share with us what is most important to you. *

_____

_____

Parent, Guardian and/or Responsible Party Information

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

The following is for:* ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:* _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Insurance Information

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Insurance Information

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

INFORMED CONSENT - Please read and check each box acknowledging that you have read the statements and agree to the contents set henceforth. *

- [ ] I, the undersigned, hereby certify that I have read and understnad the previous infromation and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inacurrate information has the potential of being hazardous to my heath.
- [ ] I hereby authorize radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for the treating doctor to make a thorough dental diagnosis. I also authorize all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy agents indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor to choose and employ such assistance as deemed fit to provde recommended treatment.
- [ ] I understand that appointments are pre-appointed and it is my responsibility to keep my appointment or to reschedule with a minimum of 48 hour notice. Failure to give sufficient notice will result in a charge being added to the account.
- [ ] As a courtesy to you, this office will prepare and submit insurance claims and assist you in collecting payment from your insurance company. I agree if my insurance denied all or part of the treatment charges for any reason, or if I am ineliglbe at the time of service, I will be personally and fully responsible for payment. Deductibles and copayss cannot always be predicted at the time of service, as benefits can change throughout the year.

*

- [ ] It is ultimately the responsibility of the patient/payee to communicate directly with their insurance carrier to determine the final cost of treatment. I consent and agree to be financially responsible for payment of all services rendered on myself and/or my dependents.
- [ ] I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Response Date: _____