Welcome to Ocotillo Dental Care. Please fill out this form completely and print clearly. If you have any questions we will be glad to help you.

Patient Information:

Today's Date:_____

Name:_____ Nickname_____

Home Address:_____ City:_____ State:_____Zip:_____- -_____

Sex: M___ F___ Age:_____ Birthdate:_____ Marital status: Single:____ Married:____ Divorced:____Widowed:____

Patient SS#: _____---_____---_____ Best time and place to reach you:_____Cell Phone (____)_____

Occupation:_____ Employer:_____Employer phone: (____)_____

E-mail Address:_____ Driver's License#_____ Home phone (____)_____

If the patient is a student: School:_____ Grade:_____

How did you hear of us? (passed by office, web site, person's name) _____

In case of Emergency, Contact: Name:_____ Relationship:_____Phone:(____)_____

Account Information:

PERSON RESPONSIBLE FOR THIS ACCOUNT:_____Relationship:_____

SS#:_____---_____---_____ Birthdate:_____ Driver's License #:_____

Phone numbers: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Occupation:_____ Employer:_____

Employer Address:_____ Employer phone: (____)_____

Insurance:

Name of Insured (PERSON WHO HOLDS THE INSURANCE):_____

SS#:_____---_____---_____ DOB:_____

Relationship to patient:_____Insurance Co.:_____Grp #:_____

Is patient covered by additional dental insurance? Yes_____ No____

Name:_____SS#:_____---_____---_____DOB:_____

Relationship to patient:_____Insurance Co.:_____Grp#:_____

Medical Insurance Company:_____SS#:_____---_____---_____Grp#:_____

Name of Insured:_____DOB:_____

Assignment and Release:

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO Dr. Garelick ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I FURTHERMORE UNDERSTAND THAT IF MY ACCOUNT BECOMES DELINQUENT, AND THIS OFFICE TURNS MY ACCOUNT OVER TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY FEES THAT ARE INCURRED IN THE PROCESS, AS WELL AS THE BALANCE OWED.

_____

Responsible Party Signature Relationship Date