Oakridge Smiles
5406 Thornwood Dr. Ste 100 San Jose, CA 95123

Patient Information

Patient Name: _____ ☐ Male ☐ Female
Last First MI

What do you prefer to be called: _____ Birth Date: _____ Age: _____ SS#: _____

Home Address: _____ Home Ph: _____
Number Street City Sate Zip

Employer: _____ Occupation: _____ Cell Ph: _____

Work Address: _____ _____ Work Ph: _____
Street City Sate Zip

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed E-mail: _____

Spouse's Name: _____ Do you have children? ☐ No ☐ Yes How many? _____

Whom may we thank for referring you? _____

Primary Dental Insurance

Company Name: _____ Phone: _____

Address: _____
Street City State Zip

Insured's Name: _____ Insured's SS#: _____ Group# _____

Insured's Employer: _____ Insured's Relation: _____ Date of Birth: _____

Initial: _____ **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.**

Secondary Dental Insurance

Company Name: _____ Phone: _____

Address: _____
Street City State Zip

Insured's Name: _____ Insured's SS#: _____ Group# _____

Insured's Employer: _____ Insured's Relation: _____ Date of Birth: _____

Initial: _____ **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.**

Financial Information – Person Ultimately Responsible for Account

Name: _____ ☐ Male ☐ Female
Last First MI

Billing Address: _____ Work Ph: _____
Street City State Zip

SS#: _____ Driver's License #: _____ Relationship to Patient: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card Card No. _____ Exp. _____/_____

In Event of Emergency

Whom should we contact? _____ Relation: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Who is your Medical Doctor? _____ Medical Doctor's Ph: _____

Please initial for acknowledgement of receipt of the HIPPA privacy policy and the Dental Material Fact Sheet.

I have received a copy of HIPPA policy _____ I have received a copy of DMFS _____