Thank you for selecting American Dental Care team! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us.

*Receptionist:*________________________

***Fecha:*____-____-*201*___**

Reason for your visit: Dental check up: Yes___ NO___, Emergency: Yes___ NO__ UR__ LR__ UL__LL__

Patient's Information: (confidential)   *Chart #*____________-___

*Name*____ *DOB* _____-_____-_____ *Sex: F* ___*M*___

Home Address ______________________________*City*___ ____________________ *Zip Code* _________

Home Phone # (____) _____-________ *email address:* ______________________________________

Responsible Party:

Responsible party's name ____ *Relationship*__________

Home Address ________________________________ *City* ___________________ *Zip Code* __________

Home phone# (____) ____-_________ *email address*____ ____________________________________

DOB ______-_____-_____ *# CID*________ _______________ *SS#* ________-________-________

Employer ____ *Phone#* (_____) _____-________

*Is this person currently a patient? Y*___ *NO*____ *How did you hear about us*__ _________________________

Names of 2 people that knows you:

1.____ *Tel#* (___)____-_____ *Relationship*______________

2.____ *Tel#* (___)____-_____ *Relationship*______________

Dental Insurance Information:

Name of Insured Person ____ *Relationship*___________

DOB _____-____-______ *SS#* ______-_____-______ *CID #* _______________ *Member ID#*______________

*Employer*____ *# Phone* (_____)_____-__________

Address _____________________________ *City* _________________ *State*____ *Zip Code* ___________

*Insurance Co. Name*____ *Phone #* (_____)_______-________

*Address*_________________________________ *City* __________________*State*_____ *Zip Code*________

ID # ____________________________ *Group #* ______________________ *Local #* ________________

Dependent Coverage Yes ____ *NO* ______ *web page address:* www.____________________________

Office use only

Dental Eligibility check: **Yes**___ **No**___ *Dependents Coverage* **Yes**___ **NO** ___ **Denti-Cal: Yes**___ **No** ____