Sutter Terrace Dental Group *Account # _____Dr#_____*

Confidential Patient & Responsible Party Information

Patient Name: _____ **Preferred Name** _____ **Male /Female**
Last First M..I.
Birth Date: _____ Patient's Social Security #: _____

Address: _____
Street City State/Zip Code

Home phone: (____)_____ Cell phone: (____)_____ Work: (____)_____Ext: _____

May we call you at work? Yes No Hours: _____ Email: _____

Emergency contact: _____ Phone: (_____)_____

_____ Relationship: _____
Street City State/Zip Code

If patient is a minor or dependent, name of Responsible Party: _____
Relationship

Other family members who are patient's of ***Sutter Terrace Dental Group***_____

Employment Information

Employer/Responsible Party___ _____ Occupation: _____

Address: _____
Street City State/ Zip Code

Phone: (_____)_____ Hours: _____ Relationship to Patient _____Driver's License_____

Dental Insurance Information (Primary)

Policyholder: _____ Relationship to Patient: _____
Last First
Employer: _____ Insurance Company/Plan: _____

Policy Holder's Birth Date: _____ SS# or ID #: _____ Group #: _____

Policy Holder's Address (if different from above): _____
Street City State/Zip Code

Is the Patient a full-time college student? Name & address of college? _____

Is the Patient insured under an additional policy? Yes No If yes, please complete Secondary Dental Insurance Information below.

Dental Insurance Information (Secondary)

Policyholder: _____ Relationship to Patient_____
Last First
Employer: _____ Insurance Company/Plan_____

Policy Holder's Birth Date: _____ SS # or ID#: _____ Group #:_____

Policy Holder's Address (if different from above): _____
Street City State/Zip Code

How did you learn about our practice?

☐ *Sutter Terrace* patient _____ ☐ *Sutter Terrace* website ☐ Location ☐ TV/Radio
☐ Newspaper/Magazine _____ ☐ Insurance company list/website ☐ Other _____

Payment for Services & Notice of Privacy Practices

Payment for dental services is due and payable at the time of treatment. A written Financial Estimate will be prepared prior to treatment. If you have dental insurance we will prepare and submit your dental claims. The patient or responsible party listed above is responsible for all charges, regardless of insurance coverage. I have received a copy of the Notice of Privacy Practices.

_____ _____ _____
Signature of patient, responsible party or guardian ***Relationship to patient*** ***Date*** *NP Confidential 3/08*