Patient Information

DENTALCARE
ROLAND L. ELAZEGUI, DMD, INC.

Welcome! We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. This information is necessary for our files and will be considered *confidential*.

If you have questions, we will be glad to help you. We look forward to working with you and maintaining your dental health!

Patient's Name *First* _____ *Last* _____ *Middle Initial* _____ SSN _____

Preferred Name _____ Age _____ Date of birth _____ ☐ F ☐ M ☐ Rather not say ☐ O _____

If patient is a minor, give name of parent of legal guardian _____ Relationship _____

Patient Address *Street* _____ *City* _____ *Zip Code* _____

Marital Status ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Cell Phone (_____) _____ - _____ Home (_____) _____ - _____ Email _____

What's your prefered method of contact? _____ Consent to receive email+text messages *Patient Initials* _____

Employed by _____ Occupation _____ Work Phone (_____) _____ - _____

If you're a college student, school attending _____ ☐ Full Time ☐ Part Time

Whom may we thank for referring you? _____

Emergency Contact Information

Emergency Contact _____ Relationship _____

Complete Address *Street* _____ *City* _____ *Zip Code* _____

Cell Phone (_____) _____ - _____ Home (_____) _____ - _____ Work (_____) _____ - _____

Primary Insurance Information

Insured Person's Info *Full Name* _____ *Date of Birth* _____ *Social Security No.* _____

Address of Insured *Street* _____ *City* _____ *Zip Code* _____

Relationship to Insured _____ Name of insurance company (primary) _____

Name of Group Dental Plan _____ *Group No.* _____ *Plan No.* _____

Name of Union _____ *Local* _____

Additional Insurance Information

Insured Person's Info *Full Name* _____ *Date of Birth* _____ *Social Security No.* _____

Address of Insured *Street* _____ *City* _____ *Zip Code* _____

Relationship to Insured _____ Name of insurance company (primary) _____

Name of Group Dental Plan _____ *Group No.* _____ *Plan No.* _____

Name of Union _____ *Local* _____

Statement of Consent: Financial Responsibility and Information Release

1. I understand that I am expected to check with my insurance company regarding covered benefits.
2. I authorize the use of this signature on all insurance submissions.
3. I authorize the dentist to release all information necessary to secure the payment of benefits.
4. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.
5. I authorize my insurance company to make payments directly to Roland L. Elazegui, DMD, Inc.

Signature _____ Date _____