Galdos Dental

Patient Information (Confidental)

Name : _____Preferred Name :_____

Birthdate_____Male___Female____ Social Security#:_____

Home#:_____Cell#:_____Work#:_____

Email:_____

Preferred ContactMethod:_____**Text OK? Yes or No**

Address:_____

City_____State_____Zip Code_____

____Single ___Married___ Divorced___Widowed

Name of Spouse _____

Are any Other family members patients at Galdos Dental ? YES____ NO_____

How do you plan to take care if this account? Cash/Credit Card?/ Care Credit/ Lending Club ?

How did You hear about us?_____

Nearest Person not living with you whom we may call **in case of an emergency:**

Name:_____ **Relationship**_____**Phone:**_____

INSURANCE: leave blank if you have no insurance

Name of insured _____Birthdate _____

Relationship to patient _____social security _____

Name of employer _____

Insurance Company _____Phoe Number_____

Group #_____Indetification /Member #_____

Insurance Co.Address_____

City _____State:_____Zip Code_____

I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to child or me during the period of such dental care to third party payers and / or health practitioners. I understand I am responsible for any and all payments through the service of a collection agency, I shall be responsible for any incidental expenses, including collection cost/attorney fees.

Patient (or Guardian)_____**Date:**_____