Rancho Bernardo Cosmetic & Family Dental Care 12405 Rancho Bernardo Road, San Diego, CA 92128

Patient Information Form

Today's Date________________

First Name________________ MI________ Last________________

Social Security Number______-______-______ Date of Birth Day______ Mo.______ Year______

Age ____ Male [ ] Female [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ]

Address Street________________ City________________ State______ Zip______

Phone: Home (______)________________ School / College ________________ Circle - Full or Part Time

Emergency Contact________________ Emergency Phone# (______)________________

Responsible Party Information

E-Mail ________________

First Name________________ MI________ Last________________

Address street________________ City________________ State______ Zip______

Social Security Number______-______-______ Date of Birth Day______ Mo.______ Year______

Insurance Carrier________ Group #________ Secondary Ins.________________ Group #________

Employer________________ Address________________ State______ Zip______

Phone: Home (______)________________ Phone: Work (______)________________

Phone: Cell (______)________________

Military Information Branch________ Rank________ Rotation Date________
Ship / Duty Station________ Pay Grade________ Discharge Date________

Spouse Information

E- Mail ________________

First Name________________ MI________ Last________________

Address street________________ City________________ State______ Zip______

Social Security Number______-______-______ Date of Birth Day______ Mo.______ Year______

Insurance Carrier________ Group #________ Secondary Ins.________________ Group #________

Employer________________ Address________________ State______ Zip______

Phone: Home (______)________________ Phone: Work (______)________________

Phone: Cell (______)________________

Military Information Branch________ Rank________ Rotation Date________
Ship / Duty Station________ Pay Grade________ Discharge Date________

Authorization To Release Information

I hereby authorize any provider, insurer or other organization to release any information regarding the dental history, treatment or benefit's payable for this claim(s) to the Plan Administrator or it's authorized agent for the purpose of determining benefit's payable.

Signature of patient, parent or legal guardian ________________ Date ________

Authorization to Pay Benefits to Dentist

I hereby authorize payments directly to Mobilia DMD Inc. or to Rancho Bernardo Cosmetic & Family Dental Care, of the dental benefits other wise payable to me.

Signature of patient, parent or legal guardian ________________ Date ________

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. ________________(initials)