Dental Oasis
Family Dentistry

925-846-4491 925-846-1422
office@dentaloasispleasanton.com

PATIENT FORM

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance

Subscriber Name _____ Subscriber ID _____

Date of Birth _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name _____

Employer Phone _____ Insurance Company _____

Insurance Group _____ Insurance Phone _____

Secondary Insurance

Subscriber Name _____ Subscriber ID _____

Date of Birth _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name _____

Employer Phone _____ Insurance Company _____

Insurance Group _____ Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone (☐ Mobile ☐ Work ☐ Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible Party, if under 18)