



Name: _____ Birthdate: ___/___/___
 Preferred To Be Addressed As: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____
 E-mail Address: _____
 How Do You Prefer We Contact You? Home Work Cell E-mail
 Employer: _____ Occupation: _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____
 Marital Status: Single Married Spouse's Name: _____
 Names of Other Family Members: _____
 Special Interests You Enjoy To Relax: _____
 Whom May We Thank For Referring You? _____
 Person To Contact In Case of Emergency: _____
 Relationship: _____ Phone: _____

ACCOUNT INFORMATION

Person Responsible For Payment: _____ Relation: _____
 Address of Responsible Party (If Different): _____
 City: _____ State: _____ Zip: _____
 Responsible Party's SS#: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: _____ Group No: _____
 Insurance Company Address: _____ Phone No: _____
 City: _____ State: _____ Zip: _____
 Insured's Name: _____ SS or ID No: _____ Birthdate: ___/___/___
 Insured's Employer: _____

Secondary Dental Insurance

Insurance Company Name: _____ Group No: _____
 Insurance Company Address: _____ Phone No: _____
 City: _____ State: _____ Zip: _____
 Insured's Name: _____ SS or ID No: _____ Birthdate: ___/___/___
 Insured's Employer: _____

AUTHORIZATION AND RELEASE

Your payment/insurance co-payment is due at the time service is rendered. We accept cash, check and credit cards.

I authorize Oak Valley Dental Associates to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Oak Valley Dental Associates insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____
 Signature of patient (or parent if minor)