torrado DENTAL

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on these forms are important to your dental health. If you have any questions, don't hesitate to ask. Thank you for choosing Torrado Dental.

Patient Information

If the patient is under the age of 18, this form must be completed and signed by a parent or legal guardian.

(Please Print)

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Employer/Occupation: _____ Bus. Phone: _____ SS #: _____

Emergency contact name and phone #: _____

Name of your medical doctor: _____ Doctor phone #: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

How did you hear of us?_____ Referred to us by: _____

Insurance Information

(Office Use Only)

Primary dental insurance: _____ Sub ID #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

P:_____ B:_____ M:_____ Max:_____ Ded:_____

Secondary dental insurance: _____ Sub ID #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

P:_____ B:_____ M:_____ Max:_____ Ded:_____

I agree that the above information was correctly provided to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes to the information I have provided.

Patient/Legal Guardian Signature:_____
Date:_____

Print Name:_____ Relationship to patient:_____

Patient/Legal Guardian Signature:_____ **Updated on:**_____