SANTA ANA DENTAL GROUP

Affordable and comfortable dental care

Welcome

Date: ____________________

ID/DL #____________________

SS#____________________

Patient Information *(CONFIDENTIAL)*

Cell Phone __________________________

Name ____ Birthdate________________ Home Phone __________________________

Address ____ City________________________ State_________ Zip Code___________

E-Mail Address____

Check Box: Minor ○ Single ○ Married ○

Patient's Employer____ Work Phone: ______________________

Employers Address____ City____________________ State_________ Zip ___________

Person to contact in case of emergency ____ Phone_____________________________

Insured/Parent

(Same As Above)

Name ____ Birthdate____________________ Home Phone _______________________

Address ____ City________________________ State_________ Zip Code_________

ID/DL # ___________________________ SS#_______________________________ Relationship To Patient____________________

Patient's Employer____ Work Phone: ____________________________

Employers Address____ City____________________ State_________ Zip ___________

Referral Information

Were you referred by one of our patients? ○ Yes ○ No

If Yes, Whom may we thank? ____

If No, How did you find our office? ____

HIPPA Acknowledgement

I have read and been offered a copy of the Santa Ana Dental Group Notice of Privacy Practices.

Signature of patient or parent (If minor) ____

Print name of patient or parent (If minor) ______________________________________ Date_______________________