MONTECITO DENTAL GROUP

□ Benedetto □ Scarcello □ Shepard

Date: _____ Email address: _____

Patient Information:

□ Married □ Single □ Minor Date of Birth _____

Name _____ □ **Male** □ **Female**
Last **First** **Middle**

Mailing Address _____
Street **Apt#** **City** **State** **Zip**

Street Address _____
Street **Apt#** **City** **State** **Zip**

Telephone _____ _____
Home **Work or Other**

Social Security # _____ **Employer/School** _____

Family Information:

(Circle One) Father Husband (Circle One) Mother Wife

Last First MI	**Last First MI**
Street City State Zip	**Street City State Zip**
Home Telephone Work Telephone	**Home Telephone Work Telephone**
Date of Birth Social Security #	**Date of Birth Social Security #**
Employer	**Employer**

Guarantor and Insurance Information:

□ Patient □ Mother □ Father □ Wife □ Husband □ Other _____

Name: _____
Address: _____
Telephone: _____
Dental Insurance Company: _____
Subscriber: _____
I.D. (SS#): _____ Group #: _____
Insurance Company Telephone #: _____

Person to Contact in Case of Emergency:

Name: _____
Address: _____
Telephone: _____

Acknowledgement and Authority:

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information in this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payors and/or other health professionals. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

Sign & Date: _____

Has any member of your family been treated in our office? Yes No Name: _____

Who may we thank for referring you to our practice? _____