San Ramon Valley Dental
Dr. Paul Fillet

NEW PATIENT FORM

ABOUT YOU

Today's Date: _____ Email Address: _____

Last Name: _____ First Name: _____

I prefer to be called: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Seperated

Birthdate: _____ Age: _____ Soc. Sec. #: _____ Gender: ☐Female ☐Male

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

Driver's License #: _____ **Whom may we thank for referring you?** _____

Other family members seen by us: _____

In Case of Emergency, Whom Should We Contact:

Name: _____ Relation: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Person Responsible for Account:

Name: _____ **Relation:** _____ **Phone:** _____

Address: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Group: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insured's Birthdate: _____ Relation: _____

Employer's Name & Address: _____

_____

Secondary Insurance: (if applicable)

Insurance Co. Name: _____ Phone: _____ Group: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insured's Birthdate: _____ Relation: _____

Employer's Name & Address: _____

_____

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between the dentist(s) and myself and/or to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 23% APR or 1.92% per month will be applied to accounts pas due 90 days or more.

Patient Signature: _____ Date: _____