HOLISTIC DENTAL CENTER

Discover the missing link to better health

Patient Information

(This information is necessary for our files and will be considered confidential)

Name of Patient _____ Date _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Pager _____

FAX _____ Email _____ Preferred Name _____

Best time and place to reach you: _____

Age _____ Date of Birth ___/___/___ Sex ☐ Male ☐ Female Marital status _____

Social Security No. _____ CA Driver's Lic. No. _____

Occupation _____ Employer _____

Work Address _____ City _____ Zip _____

Spouse/Partner Information: Name _____ Phone _____

Occupation _____ Employer _____

Address _____ City _____ Zip _____

Nearest relative not living with you: Name _____ Phone _____

Address _____ City _____ Relationship _____

In case of emergency, contact: Name _____ Phone _____

Whom may we thank for referring you? _____ City _____

Who will be responsible for paying your account? _____

How do you plan to pay for your account? ☐ Cash ☐ Check ☐ Credit Card

Do you have dental insurance? _____ Name of Insured _____

Insurance Company _____ Phone _____

Address _____ City _____ Zip _____

Policy No. _____ Subscriber No. _____

Social Security No. _____ Group No. _____

Do you have dual coverage? Information: _____

Payment is due and payable on the day of treatment. Professional services are charged directly to the patient, and the patient is solely and personally responsible for payment. As a courtesy, we will submit insurance claims to your insurance provider and will assist you in obtaining reimbursements for treatment that is covered under the provisions of your policy, which can be explained by your carrier or your employer. Please familiarize yourself with this information. We do not render services on the assumption that the insurance company will pay any or all of our fees. Payment is expected the day of treatment, unless prior arrangements have been made. A service charge of 1½% per month will be added to unpaid balances on all accounts not paid by the agreed upon date. Where appropriate, credit bureau reports may be obtained.

As a courtesy, we will confirm your appointment by telephone. Our office and staff are reserved for you and your care during your appointment time. **IF YOU CANNOT KEEP YOUR APPOINTMENT, YOU MUST INFORM US AT LEAST 24-HOURS IN ADVANCE. IF WE ARE NOT NOTIFIED OF YOUR CHANGE OF PLANS 24-HOURS AHEAD OF TIME, WE WILL CHARGE YOU FOR THE TIME RESERVED FOR YOU AT A RATE OF $200 PER HOUR.**

It is the patient's responsibility to advise our office of any changes in the information contained on this form.

I, the undersigned, understand and agree to the above:

_____ Signed _____ Date

DR. RAUL VELAZQUEZ, D.M.D.

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