

Welcome

Thank you for selecting us to help you become healthier! To help us understand and meet your dental needs, please fill out these forms for us. We will always encourage you to take better care of yourself knowing that inaction leads to problems later.

Personal Information:

Name _____ Social Sec. # _____ Birth Date _____

Mailing Address _____

City / State/ Zip _____

Wish to be called _____ Male Female

Emergency Contact Name _____ Phone # _____

Your Employer _____ Your Occupation _____

Employer Address _____

Insurance Carrier _____ Group Number _____

Responsible Party – Insured – if different from above

Name _____ Relation to patient _____

Mailing Address _____

Birth Date _____ Social Sec. # _____

Employer _____ Occupation _____

Employer Address _____

How Can We Contact You?

Home Phone _____ Work Phone _____ Ext. _____

Cellular Phone _____ Pager _____

Email Address _____

Authorization Release

I authorize Dr. Abeyta or her employees to release information concerning my dental treatment or that of any dependent children who are patients of Dr. Abeyta to third party payers and/or other health practitioners.

Signature of patient or parent of minor