☐ Separated ☐ Widowed
☐ Divorced ☐ Single
☐ Child ☐ Married

PLEASE ANSWER EACH QUESTION & COMPLETE

PATIENT INFORMATION

NAME_____ BIRTHDATE_____SEX_____
SOC. SEC. NO. _____HOME PHONE ( ) _____ WORK/CELL ( ) _____
ADDRESS _____CITY _____ ZIP _____
SCHOOL (if full-time student) _____
PREVIOUS DENTIST _____CITY _____ LAST VISIT _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
EMAIL ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME (Subscriber) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____SOC.SEC. NO _____DOB _____
EMPLOYER _____ ADDRESS _____
CITY _____ ZIP _____
WORK/CELL PHONE ( ) _____HOME PHONE ( ) _____
INSURANCE COMPANY _____GROUP NO. _____

SECONDARY INSURANCE

Fill out if patient is covered by another insurance plan

NAME (Subscriber) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____SOC. SEC. NO _____DOB _____
EMPLOYER _____ADDRESS _____
CITY _____ZIP _____
WORK/CELL PHONE ( ) _____HOME PHONE ( ) _____
INSURANCE COMPANY _____GROUP NO. _____

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor or his qualified designate.

I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, **at the time of service**, unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a service charge of $5.00, and I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account. I understand that where appropriate, a credit check may be made through a credit bureau.

INSURANCE RELEASE

I hereby authorize insurance benefit payments directly to COLIN S. ILAS D.M.D. for his services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original.

I authorize COLIN S. ILAS, D.M.D. to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

✖ Signed: _____Date: _____
Patient or Assigned Representative

ILAS DENTAL CARE
1206 N. Capitol Avenue, Suite 101 San Jose, CA 95132 (408) 928-1450
2030 Diamond Blvd. Suite 25 Concord, CA 94520 (925) 687-8000