PLEASE ANSWER EACH QUESTION & COMPLETE

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

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ SEX _____
SSID # _____ HOME PHONE ( ) _____ CELL ( ) _____
ADDRESS _____ CITY _____ ZIP _____
EMAIL ADDRESS: _____
SCHOOL (if full-time student) _____
PREVIOUS DENTIST _____ CITY _____ LAST VISIT _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME (Subscriber) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____ SSID # _____ BIRTHDATE _____
EMPLOYER _____
ADDRESS _____ CITY _____ ZIP _____
BEST PHONE # TO REACH ( ) _____
INSURANCE COMPANY _____ GROUP # _____

SECONDARY INSURANCE Fill out if patient is covered by another insurance plan

NAME (Subscriber) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____ SSID # _____ BIRTHDATE _____
EMPLOYER _____
ADDRESS _____ CITY _____ ZIP _____
BEST PHONE # TO REACH ( ) _____
INSURANCE COMPANY _____ GROUP # _____

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

X Signed: _____ Date: _____

X Signed: _____
Date: _____

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.

X Signed: _____
Date: _____

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.

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