Valley Village DENTAL

Let Our Family Take Care Of Yours

PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

TODAY'S DATE:_____ **WHOM MAY WE THANK FOR REFERRING YOU?**_____

PATIENT'S NAME:_____ NICKNAME/PREFER TO BE CALLED:_____
Last First Middle

PATIENT'S ADDRESS:_____
Street Apt City State Zip

ALTERNATE/MAILING ADDRESS:_____
Street Apt City State Zip

CONTACT NUMBERS: (____)_____ (____)_____ (____)_____ (____)_____
Home Cell Work Other

E-MAIL:_____ FACEBOOK:_____

PREFERRED METHOD OF COMMUNICATION (CHECK AS MANY AS YOU'D LIKE): ☐Phone ☐E-mail ☐Facebook (private message) ☐Text to cell phone

SEX: ☐Male ☐Female DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____
Month/Day/Year

MARITAL STATUS: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed SPOUSE'S NAME:_____

OCCUPATION:_____

EMPLOYER'S NAME:_____ EMPLOYER'S PHONE: (____)_____

EMPLOYER'S ADDRESS:_____
Street City State Zip

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME:_____

ADDRESS:_____
Street Apt

_____
City State Zip

CONTACT NUMBERS: (____)_____ (____)_____
Home Cell

(____)_____ (____)_____
Work Other

RELATIONSHIP:_____

NAME:_____

ADDRESS:_____
Street Apt

_____
City State Zip

CONTACT NUMBERS: (____)_____ (____)_____
Home Cell

(____)_____ (____)_____
Work Other

RELATIONSHIP:_____

IF THE PATIENT IS UNDER 18 YEARS OF AGE:

PARENT/LEGAL GUARDIAN:_____
Last First Middle

ADDRESS:_____
Street Apt City State Zip

ALTERNATE/MAILING ADDRESS:_____
Street Apt City State Zip

CONTACT NUMBERS: (____)_____ (____)_____ (____)_____ (____)_____
Home Cell Work Other

SEX: ☐Male ☐Female DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____
Month/Day/Year

MARITAL STATUS: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed SPOUSE'S NAME:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____

SUBSCRIBER:_____
Last First Middle

SOCIAL SECURITY #:_____ DATE OF BIRTH:_____
Mo/Dy./Yr.

POLICY/GROUP #:_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

EMPLOYER'S PHONE #:(____)_____

SECONDARY INSURANCE:_____

SUBSCRIBER:_____
Last First Middle

SOCIAL SECURITY #:_____ DATE OF BIRTH:_____
Mo/Dy./Yr.

POLICY/GROUP #:_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

EMPLOYER'S PHONE #:(____)_____

I certify that all the above information is true and correct to the best of my knowledge as of the date indicated below. I understand that I am financially responsible for all charges, whether or not paid by my insurance company.

_____ _____
Responsible party signature Date

By signing this form, I assign all insurance benefits for services rendered, otherwise assignable to me, to Drs. Grosleib and/or Valley Village Dental. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible party signature Date