EAST BAY
Oral Surgery
& Dental Implant Center

Registration

Patient's name _____ Date of Birth _____
Last First Middle initial

Patient Social Security number _____ Single ___ Married ___ Div/Wid ___ Minor___

Residence – Street _____

City _____ State _____ Zip _____

Telephone: Res. _____ Cell _____

Employed by _____

Employer telephone _____

Spouse/Parent name _____

Who is responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance _____ Cash _____ Credit Card _____

Whom may we thank for this referral _____

Someone to notify in case of emergency not living with you _____ phone # _____

Insurance Information

Dental

Name of insurance company _____

Insured employee name _____

Insured SS# _____ DOB _____

Insured employer _____

Subscriber ID#/ Policy # _____

Group# _____ Ins. Phone# _____

Medical

Name of insurance company _____

Insured employee name _____

Insured SS# _____ DOB _____

Insured employer _____

Subscriber ID#/ Policy # _____

Group# _____ Ins. Phone # _____

Secondary Dental

Name of insurance company _____

Insured employee name _____

Insured SS# _____ DOB _____

Subscriber ID#/ Policy # _____

Group# _____ Ins. Phone# _____

Release: I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose or evaluating and administering claims for insurance benefits and information provided to another dentist.

I attest to the accuracy of the information on this page: _____
Patient or guardian's signature date