Sequoia Dental Office
5601 W. Hillsdale
Visalia, CA 93291
Tel: (559) 635-7186
www.sequoiadental.com

Patient Number _____

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____
Last First Initial Date of Birth (mm/dd/yy)

❑ Male ❑ Female Age: _____ SSN#: _____ -_____ - _____

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact Person: _____ Phone: _____

Occupation: _____ Employer: _____

Employer's Address: _____
Street City State Zip Code

Do you have a personal physician?
❑ Yes ❑ No

Physician's Name: _____ Phone: _____

DENTAL INSURANCE

Primary Insurance

Insurance Company Name: _____

Address: _____

Group or Plan ID: _____

Insured's Name: _____

Relation to patient:
❑ Self ❑ Spouse ❑ Parent

Insured's Social Security Number: _____

Birth date: _____

Employer: _____

Secondary Insurance

Insurance Company Name: _____

Address: _____

Group or Plan ID: _____

Insured's Name: _____

Relation to patient:
❑ Self ❑ Spouse ❑ Parent

Insured's Social Security Number: _____

Birth date: _____

Employer: _____

AUTHORIZATION AND RELEASE
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

PATIENT or GUARDIAN SIGNATURE_____ DATE_____