

**Sala Family Dentistry
4875 Summit Ridge Dr.
Reno, Nv 89523**

PERSONAL INFORMATION

Date: _____

Patient Name: _____ Soc. Sec. #: _____ - _____ - _____

Date of Birth: ____/____/____ Sex: Male / Female Married / Single / Divorced / Widow

Address: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

E-Mail: _____

Employer: _____

How Long?: ____ years, ____ months Employer Phone: (____) _____

Employer Address: _____

Spouse's Name: _____

Date of Birth: ____/____/____ Employer: _____

Employer Phone: (____) _____

Who to call for an emergency:

Name: _____

Home Phone: (____) _____ Work Phone: (____) _____

Address: _____

Relationship: _____

How did you hear about our Practice?: _____

Turn Over →

PATIENT FINANCIAL INFORMATION

Person responsible for bill (if other than patient):

Guarantor Name: _____ Soc. Sec. #: _____ - _____ - _____

Date of Birth: ____/____/____ Relationship to Patient: _____

Address: _____

Home Phone: (____) _____ Cellular Phone: (____) _____

Employer: _____ Employer Phone: (____) _____

Primary Insurance Information:

Dental Insurance Company: _____ Phone: (____) _____

Address: _____

Employer: _____ I.D. Number: _____

Policy Holder: _____ Group Number: _____

Policy Holder's Date of Birth: ____/____/____ Effective Date: _____

Relationship to patient: _____

Secondary Insurance Information:

Dental Insurance Company: _____ Phone: (____) _____

Address: _____

Employer: _____ I.D. Number: _____

Policy Holder: _____ Group Number: _____

Policy Holder's Date of Birth: ____/____/____ Effective Date: _____

Relationship to patient: _____

The information I have given above is accurate to the best of my knowledge.

PATIENT (or guardian) **SIGNATURE** _____ **DATE** _____

GUARANTOR SIGNATURE _____ **DATE** _____
(if other than patient)