

Welcome to
YA Family Dental
New Patient Information

Patient Information			
_____			Data of Birth _____
Last Name _____	First _____	Middle Initial _____	
Social Security # _____	Driver's License # _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address _____		Apt #: _____	
City _____	State _____	Zip _____	Home Phone # () _____
Email _____		Cell Phone # () _____	

Dental Insurance Information	
Do you have Dental Insurance, Medi-Cal or Denti-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No Please present card to receptionist.	
Insurance Company Name _____	Group # _____
Name of Insured person (<input type="checkbox"/> Self) _____	Your relationship _____

Emergency Contacts	
Name of Your Medical Insurance: _____ <input type="checkbox"/> Full, <input type="checkbox"/> HMO, <input type="checkbox"/> PPO, <input type="checkbox"/> Medicare, <input type="checkbox"/> None	
Person to notify in case of emergency, if no one is at your home during the emergency? Relationship _____	
Name: _____	Phone # () _____
Address: _____	City _____ State _____ Zip _____

Employment Information	
Employed By: _____	Employer Phone # : () _____
Work Address: _____	City _____ State _____ Zip _____
Monthly Income? _____	Years Employed? _____ Yrs. _____ Mos. Occupation/Department _____

Personal References

Name: _____ Phone # (_____) _____

Address: _____ City _____ State _____ Zip _____

Name: _____ Phone # (_____) _____

Address: _____ City _____ State _____ Zip _____

Responsible Party (Any Other Person Who Will Help Pay for the Dental Care)

Relationship to Patient: Parent, Spouse, Co-Signer, Guardian

Social Security # _____ Driver's License # _____ Home Phone # (_____) _____

Address: _____ City _____ State _____ Zip _____

How long at this address _____ Yrs. _____ Mos. Own Rent

Responsible Party's Financial /Employment Information

Employed By: _____ Employer Phone # : (_____) _____

Work Address: _____ City _____ State _____ Zip _____

Monthly Income? _____ Years Employed? _____ Yrs. _____ Mos. Occupation/Department _____

How did You Hear about YA Family Dental?

- Yellow Pages Flyer to Home Newspaper Saw Sign
 Preferred Provider Flyer
 Employer WIC or County School Referral Denti-Cal Referral

Referred by Friend. Who : _____ Phone # (_____) _____

Address: _____ City _____ State _____ Zip _____

I am aware that by signing below I certify that all information is complete and correct. YA Family Dental may verify this information from whichever source it deems necessary (including but not limited to credit report agencies) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for YA Family Dental to verify credit history.

Signature of Patient Date: _____

Signature of Responsible Party Date: _____