Rockridge Smiles
The Peterson Chan Dental Group

New Patient Information

Patient Name: _____ Birth Date: _____ Gender _____
Home Address: _____ Social Security: _____
_____ Home Phone: _____
City: _____ Zip: _____ Work Phone: _____
E-mail: _____ Cell Phone: _____
Occupation: _____ Best Contact: ❑ Home ❑ Work ❑ Cell
Referred by: _____ Emergency Contact: _____
_____ Relationship: _____

Insurance Information

Primary Carrier: *(please complete all information in full)*

Policy Holder: _____ Insurance Co.: _____
Relation to Patient: ❑ Self ❑ Spouse ❑ Parent Address: _____
Employer: _____ _____
Subscriber ID (SS or ID#): _____ Telephone #: _____
Birth Date: _____ Group #: _____

Secondary Carrier: *(if applicable)*

Policy Holder: _____ Insurance Co.: _____
Relation to Patient: ❑ Self ❑ Spouse ❑ Parent Sub ID #: _____ Birth Date: _____

Note to Insured Patients

1. We are only in-network with Delta Dental as a Premier Provider. For all other carriers, please refer to your out-of-network provision. X _____ *(initial)*
2. We will contact your Insurance Carrier for benefits, but all quotes made are estimates only. You are responsible for all fees in their entirety. X _____ *(initial)*
3. The insurance is purchased by you and/or an employer and we ask that you understand all the provisions of the policy. As a courtesy, we process insurance claims. Any portion unpaid by insurance is your responsibility. X _____ *(initial)*
4. I am responsible for notifying the office of any insurance changes. X _____ *(initial)*
5. I hereby authorize the direct payment of dental benefits to the provider. X _____ *(initial)*

Note to All Patients

1. We require that all services and co-pays are paid for at the time of service. If your treatment is extensive, a payment schedule may be arranged. X _____ *(initial)*
2. Please allow a 48-hour (two business days) cancellation for all appointments. Without sufficient notice a fee will be charged. X _____ *(initial)*
3. I hereby acknowledge that a copy of the Notice of Privacy Practices and the Dental Materials Sheet has been made available to me. I have been given the opportunity to ask any questions that I may have regarding this notice. X _____ *(initial)*

Patient Signature: _____ Date: _____