

Capitola Dental Group



Patient Information Form

Name: Last name First Name Middle Nickname:

Date of Birth: SS# Ph# (Home) Cell

Address:

Single Married Divorced Separated Widow Minor

Employer: Employer Phone:

Email address: Emergency Contact:

Family Physician: Phone #

Legal Guardian (if under 18) Contact #

Name of Person Responsible for account (if different from patient or guardian)

Previous Dentist:

Who referred you to our office?

Payment will be made by: Cash Check Credit Card Care Credit (if applicable)

Would you like to receive appointment reminders by email or text message? Yes No Email Text Both

Insurance Information:

Dental Insurance #1: Name of Insurance: Name of Insured:

Insured dob: SS# or Plan ID: Ph#

Medical Insurance #1: Name of Insurance: Name of Insured:

Insured dob: SS# or Plan ID: Ph#

Add'l Insurance: Name of Insurance: Name of Insured:

Insured dob: SS# or Plan ID: Ph#

Authorization (Please read the following information carefully) I grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary. I hereby grant payment of all medical and dental benefits directly to Robert C. Schellentrager, D.M.D.

Signature of patient or legal guardian Date