Almaden Dental Associates
Family and Aesthetic Dentistry
Meng Sym DDS Regina Grap DDS Olga Belova DDS

ABOUT YOU

Today's Date: _____ **Email address:** _____

Name (Last, First Middle): _____ **I prefer to be called:** _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐Separated

Birthday: _____ **Age:** ____ **Social Security #:** _____ **Drivers Lic:** _____

Home Address: _____

Home Phone #: (_____) _____ **Mobile:** (_____) _____ **Work:** (_____)_____

When and Where are best times to reach you? _____ **Whom may we thank for referring you?** _____

Other family members seen by us: _____

Employer: _____ **How long there:** _____ **Occupation:** _____

Employer's address: _____

Person Responsible for Account if other than yourself

Name: _____ **Relation:** _____ **Home Phone #:** _____ **Social Security #:** _____

Employer: _____ **Work Phone:** _____ **Ext.:** _____ **Drivers Lic.:** _____

Billing Address: _____
Street City State Zip

SPOUSE or PARTNER INFORMATION (if included in insurance)

Name: _____	**Birthday:** _____	**Social Security #:** _____	
Employer: _____	**Work Phone #:** _____	**Ext.:** _____	**Driver's Lic #:** _____

INSURANCE INFORMATION

Primary Dental Insurance **Dental Coverage** ☐ **Yes** ☐**No** ☐**Unsure** **Orthodontic Coverage** ☐**Yes** ☐**No** ☐**Unsure**

Insurance Co. Name: _____ **Phone Number:** _____ **Group Number (Plan, Local or Policy#):** _____

Insurance Co. Address: _____
Street City State ZIP

Insured's Name: _____ **Insured's SS#:** _____ **Insured's Birthday:** _____ **Relation:** _____

Insured's Employer: _____ **Employer's Address:** _____
Street City State Zip

Secondary Dental Insurance **Dental Coverage** ☐ **Yes** ☐**No** ☐**Unsure** **Orthodontic Coverage** ☐**Yes** ☐**No** ☐**Unsure**

Insurance Co. Name: _____ **Phone Number:** _____ **Group Number (Plan, Local or Policy#):** _____

Insurance Co. Address: _____
Street City State ZIP

Insured's Name: _____ **Insured's SS#:** _____ **Insured's Birthday:** _____ **Relation:** _____

Insured's Employer: _____ **Employer's Address:** _____
Street City State Zip

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all Insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature Date