JESUS PEREZ, DMD
FAMILY AND COSMETIC DENTISTRY

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____
Name: _____
Last First MI
I prefer to be called: _____
Male ____Female ____ Birthday: ____/____/_____
Age: ____ SS#: _____
Home Address: _____
_____
CITY STATE ZIP
Single ___Married ___ Divorced ___ Widowed___
Home #: _____Other: _____
WK#: _____ Ext.: _____
Employer: _____
Employer Address: _____
_____
How long have you worked there? _____
Occupation: _____
What time and with which number would be best used to reach you:_____
Who may we THANK for referring you to our office?
_____
Other family members seen by us: _____
_____
Previous/Present Dentist: _____
(Please circle one)
Last visit date: _____

SPOUSE INFORMATION

Their Name: _____
Employer: _____
WK# _____ Ext._____
Birthday: _____ DL #_____

PARTY RESPONSIBLE

Name: _____
Billing Address: _____
_____
Contact #: _____
SS#_____ Relation: _____

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Phone #: _____
Insurance Co. Address: _____
_____
Insured's Birthday: _____
Insured's SS #: _____
Insured's Employer: _____
Relation: _____

Secondary Dental Insurance*

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Insured Name: _____
Insured's Birthday: _____
Insured's SS #: _____
Insured's Employer: _____
Relation: _____

I hereby authorize Jesús Pérez D.M.D., PA to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization to treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Dr. Jesús Pérez, D.M.D., PA. The medical and dental insurance benefits otherwise payable to me, for the service rendered to me by Dr. Pérez or his staff. I have been informed that his office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that is the sole power and responsibility of carriers (s) to determine the actual dollar amounts of benefits for all services rendered. I understand I am ultimately responsible for the total treatment provided by Dr. Jesús Pérez or his staff. This authorization remains valid and effective from the date signed, until revoked in writing. I acknowledge that I have read and understand the above statement.

_____
Signature of Patient or Patient's Guardian Date

PLEASE COMPLETE REVERSE SIDE, THANK YOU.