

SC Dental Center • Dean Tan, DDS & Associates

Patient Information

www.scdentalirvine.com, 14785 Jeffrey Road • Suite 103 • Irvine • CA 92618 • Arbor Village Center

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date _____

Patient Name _____ Age _____ Patient's Birthday _____
LAST FIRST MIDDLE

If patient is a minor, give name or parent of legal guardian _____ Relationship _____

Residence Address _____ For how long? _____ Own Rent
STREET CITY ZIP

Patient is Single Married Divorced Separated Widowed Minor Sex: Male Female

Driver's License No. _____ Social Security No. _____ Cell () _____

Home Phone () _____ Work Phone () _____ Email Address _____

Employed by _____ How long? _____ Occupation _____

Business Address _____
STREET CITY ZIP

Spouse's name _____ Driver's License No. _____ Soc. Sec. No. _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Home Phone () _____
STREET CITY ZIP

Name of physician _____
Address TELEPHONE

Former Dentist _____
Address TELEPHONE

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____
STREET CITY ZIP TELEPHONE

PREFERENCE PAYMENT: Cash on day of treatment Visa No. _____

State Aid No. _____ Mastercard No. _____

Name of insurance company (Primary Insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Name of insurance company (Secondary Insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services finished to me are charged directly to me and that I am personally responsible for the payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to account. However, this dental office cannot render any services on the assumption the charges will be paid by an insurance company.

I have read the above conditions of treatment and agree their content.

Signature _____ Date _____