Deborah McNeil-Amorteguy, DDS, Inc.
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SAN LUIS OBISPO, CA 93401

PATIENT NAME_____ DATE OF BIRTH_____

ADDRESS _____
CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____
EMAIL _____ preference for appointment confirmation?

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

WHOM DO WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
RELATIONSHIP TO YOU _____ PHONE _____

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT _____
PHONE CONTACT FOR RESPONSIBLE PERSON_____
ADDRESS FOR BILLING STATEMENTS _____

DENTAL INSURANCE: PRIMARY INSURANCE_____
SUBSCRIBER NAME_____
IS PATIENT A STUDENT? ... FULL TIME/PART TIME?
EMPLOYER _____ GROUP # _____
SOCIAL SECURITY #_____ DATE OF BIRTH _____

DENTAL INSURANCE: SECONDARY INSURANCE_____
SUBSCRIBER NAME_____
EMPLOYER _____ GROUP # _____
SOCIAL SECURITY #_____DATE OF BIRTH _____

I AUTHORIZE DR. McNEIL-AMORTEGUY TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND TREATMENT NOTES TO HEALTH PRACTIONERS AND/OR DENTAL BENEFITS COMPANIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR ALL DENTAL SERVICES PROVIDED ME AND MY DEPENDENTS, REGARDLESS OF THE DECISION REGARDING REIMBURSEMSNT MADE BY MY INSURANCE BENEFITS PLAN. IF I AM NOT ELIGIBLE OR SERVICES ARE NOT COVERED UNDER THE TERMS OF MY BENEFIT PLAN, I AM RESPONSIBLE FOR ALL CHARGES. ANY UNPAID BALANCE, OVER 90 DAYS OLD, WILL INCUR A 1.5% FEE MONTHLY. IF I DO NOT SIGN BELOW, I UNDERSTAND MY INSURANCE COMPANY WILL NOT BE BILED FOR ANY SERVICES AND I AGREE TO PAY IN FULL FOR SERVICES PROVIDED AT EACH APPOINTMENT. I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE.

I HAVE RECEIVED A COPY OF THE STATE OF CALIFORNIA DENTAL MATERIALS FACT SHEET

PATIENT / GUARDIAN_____ DATE_____