155 NE 192nd Ave Suite 105, Camas, WA, 98607 · (360) 828-5502

# CAMAS DENTISTRY

## *Patient Information*

Today's Date: _____

Name: _____

Date of Birth: _____ □Male □Female

Home Address: _____

_____

Phone #: _____ Cell #: _____

Work #: _____

Email: _____

Employer: _____

Previous Dentist: _____

Which one of the following is the best way to reach you?

□ Home phone □ Cell phone

□ Work phone □ E-mail

How did you hear about our office?

□ Google □ Bing □ City Search □ Other: _____

_____

## *Emergency Contact*

Name: _____

Phone #:_____ Relationship:_____

## *Insurance Information*

Policy Holder's Name: _____

Employer: _____

Date of Birth: _____ Phone#:_____

Insurance Provider: _____

ID #: _____ Group #: _____

Relationship: _____

## *Secondary Insurance*

Insurance Company: _____

Insured's Name: _____

Insured's DOB: _____Relationship:_____

Insured's Phone #: _____

ID #: _____ Group # _____

What key words did you enter to find us online? (e.g. "Camas Dentist", "Emergency Dentist", etc.)

_____

I understand that I am responsible for payment of services rendered and also responsible for paying any co payments and deductibles that my insurance does not cover. I hereby authorize payment directly to Camas Dentistry for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____