Welcome to...

ORANGE TREE LANE DENTAL

PATIENT DENTAL RECORD

Please complete fully and print legibly.
All information will be held in strict confidence.

Lloyd Alfred Pragasam, DDS, Inc.
2048 Orange Tree Lane
Redlands, CA 92374
909/793-3443

PATIENT HISTORY INFORMATION

PLEASE PRINT

PATIENT'S NAME_____ PHONE: Home_____ Pager_____ Cellular_____

SOC. SEC. # _____ BIRTHDATE_____ AGE_____ SEX_____ MARITAL STATUS_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PATIENT'S OCCUPATION_____ PATIENT'S DRIVER'S LICENSE #_____

PATIENT'S EMPLOYER_____ PATIENT'S WORK PHONE_____

EMPLOYER ADDRESS_____

SPOUSE'S NAME_____ SPOUSE'S DRIVER'S LICENSE #_____

SPOUSE'S EMPLOYER_____ SPOUSE'S OCCUPATION_____

SPOUSE'S EMPLOYER ADDRESS_____ SPOUSE'S WORK PHONE_____

PERSON TO NOTIFY IN CASE OF EMERGENCY: NAME_____ PHONE_____

CLOSEST RELATIVE NOT LIVING WITH YOU: NAME_____ PHONE_____

STUDENT: ❑ FULL TIME ❑ PART TIME SCHOOL_____ CITY_____

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT? ❑ YES ❑ NO IF YES, WHEN?_____

RESPONSIBLE PARTY'S INFORMATION - Fill out if different from Patient History Information

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT_____ HOME PHONE_____ WORK PHONE_____

MAILING ADDRESS_____ CITY_____ ZIP_____

SOC. SEC. NO._____ DRIVER'S LICENSE #_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS _____ CITY_____ ZIP_____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ❑ YES ❑ NO

NAME_____ WHEN?_____

DENTAL INSURANCE ❑ YES ❑ NO

INSURED'S NAME_____

S.S.#_____ BIRTHDATE_____

EMPLOYER_____

INS. CO. or PLAN_____

UNION/GRP. NAME_____

GRP. or POLICY #_____ LOCAL#_____

DATE EMPLOYED_____

SECONDARY INSURANCE ❑ YES ❑ NO

INSURED'S NAME_____

S.S.#_____ BIRTHDATE_____

EMPLOYER_____

INS. CO. or PLAN_____

UNION/GRP. NAME_____

GRP. or POLICY #_____ LOCAL#_____

DATE EMPLOYED_____

HOW DID YOU HEAR ABOUT THIS OFFICE? ❑ ANOTHER PATIENT (WHO?_____)

❑ UNION ❑ TELEPHONE BOOK ❑ BUILDING SIGN ❑ EMPLOYER ❑ ADVERTISEMENT (WHICH?_____) ❑ OTHER?_____

WHY ARE YOU HERE TODAY? _____
(CHECK-UP, TOOTHACHE, CONSULTATION, ETC.)

CONSENT

I hereby consent to a complete comprehensive dental examination, including the use of anesthetic, sedatives, and x-rays as may be deemed necessary by the dentist.

I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier(s) for the purpose of claims administration and evaluation, utilization review and financial audit.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I also understand that the amount quoted to me as my portion for dental services is an **estimate only** and may vary according to the limitations and policies of any particular dental insurance company.

_____ _____
PATIENT DATE

_____ _____
RESPONSIBLE PARTY DATE