ACE DENTAL

1070 Pleasant Grove Blvd,
Suite #110, Roseville, CA 95678
Tel# 916-772-0111 Fax 916-772-0121
www.AceDentalRoseville.com

Welcome, Our Goal is to help you maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ____/____/____ Email: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ☐ Male ☐ Female

Birth date: ___/___/___ Age: _____ SS: _____-_____-_____

Home Address: _____

_____
City State Zip Apt/Condo #

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Hm #: (_____)_____ Pager/ Cell #: _____

Wk. #: (_____)_____ Ext: _____ DL #: _____

Employer: _____

Employer's address: _____

How long there: _____ Occupation: _____

Where & when are the best times to reach you? _____

How did you hear about us? Relative/Friend, Yellow Pages, Internet, Mailer

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Reason for leaving last dentist: _____

Last dental appointment: ☐ 6 Months/1 Year ☐ 1-2 years ☐ Over 2 years

2 Spouse Information

His/Her Name: _____

Employer: _____

Wk. #: (____)_____ Ext: _____ SS: _____-_____-_____

Birth date: ____/____/____ Driver License #: _____

Person Responsible For Account: _____

Wk. #: (____)_____ Ext: _____ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS: _____-_____-_____

Employer: _____ DL #: _____

3 Primary Insurance Coverage

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____/_____/_____ Insured's ID#: _____

Insured's Employer: _____

4 Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/____ Insured's ID #: _____

Insured's Employer: _____

5 *In the event of an emergency, Is there someone who lives near you that we should contact?*

His/Her Name: _____ **Relation:** _____

Wk. #: (_____)_____ Hm #: (____)_____

6

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover

Signature: _____ Date : _____

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that the above information is accurate and complete. I hereby authorize my insurance Company(s) to pay directly to Dr. Karanvir S. Sibia D.D.S the benefits due towards the dental treament provided to me as per the terms on my issued policy. I understand and agree that, (regardless of my personal insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I understand that a finance charge of 1.5% will be assessed on any balance over 90 days old. I will notify you of any changes in my health status or the above information.

Signature: _____ Date : _____