Advanced Dental Care
Dr. Martin J. Cisneros D.M.D.

PATIENT INFORMATION

DATE_____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME_____

DATE OF BIRTH _____/_____/_____ SEX : MALE / FEMALE MARITAL STATUS : M S D W

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

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP _____ WORK PHONE _____ EXT_____

CELL PHONE _____

SPOUSE'S NAME _____ DATE OF BIRTH _____/_____/_____

SPOUSE'S EMPLOYER _____ PHONE _____

SPOUSE'S SOC. SEC. NO._____ OCCUPATION _____

SPOUSE'S WORK ADDRESS_____

EMERGENCY CONTACT PERSON _____ RELATION _____

HOME ADDRESS _____ PHONE _____

REFERRED PHYSICIAN _____ PHONE _____

INSURANCE INFORMATION TYPE: ☐ PPO ☐ CASH

INSURANCE NAME _____ EFFECTIVE DATE _____/_____/_____

ADDRESS _____ PHONE _____

CERT #_____ GROUP # _____

SUBSCRIBER_____ SS#_____ DOB_____ RELATION _____

AUTHORIZATION TO PAY MEDICAL AND SURGICAL BENEFITS DIRECTLY TO ATTENDING PHYSICIAN:

I HEREBY AUTHORIZE MY INSURANCE _____TO MAKE PAYMENTS DIRECTLY TO: DR. MARTIN J. CISNEROS, D.M.D. FOR ALL SURGICAL AND MEDICAL EXPENSE BENEFITS OTHERWISE PAYABLE TO ME FOR THIS PERIOD OF TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE BENEFITS. I ALSO AUTHORIZE RELEASE OF MY RECORDS TO THE INSURANCE COMPANY FOR PURPOSE OF BILLING.

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PATIENT / PARENT / GUARDIAN / INSURED