GERALD T. KONDO, D.D.S.
BROOKE K. RAINS, D.D.S.
GENERAL DENTISTRY

390 SOUTH GREEN VALLEY ROAD, SUITE 2
WATSONVILLE, CALIFORNIA 95076-1305

831 728 1322 P 831 728 2778 F

Patient **Registration**

PATIENT INFORMATION

Patient Name			Date
Address			Social Security #
City, State, Zip			Birthdate / Age
❑ Male ❑ Female	❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	❑ Minor	Home Phone
Patient Employer / School			Work Phone / Extension
Address			Mobile Phone
City, State, Zip			Email
Occupation			Driver's License #
Whom may we thank for referring you?			
Who is financially responsible for this account?			Relation:

For your convenience, we offer the following methods of payment. Please check the option you prefer. ***Payment in full at each appointment.***
❑ Cash ❑ Personal Check Credit Card ❑ VISA ❑ Mastercard ❑ Discover ❑ American Express

SPOUSE INFORMATION

Name	
Birthdate	
Social Security #	
Employer	
Work Phone	
Mobile Phone	

IN CASE OF EMERGENCY CONTACT
SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD

Name	
Relationship	
Phone # 1	
Phone # 2	

DENTAL INSURANCE

Subcriber's Name	Birthdate
Relation to Patient	Social Security #
Employer	Date Employed
Insurance Co.	Subscriber ID
Group #	Insurance Phone #
Is patient covered by additional insurance?	❑ Yes (complete the following) ❑ No
Subcriber's Name	Birthdate
Relation to Patient	Social Security #
Employer	Date Employed
Insurance Co.	Subscriber ID
Group #	Insurance Phone #

Authorization *and* ***Release***

I certify that I have completed the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third-party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. *I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

Signature of Responsible Party _____ Date _____