

Patient Information Record

The following information is needed for our records. Please PRINT clearly answers to all questions.

Patient Name: _____	Employer: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Telephone: _____	Telephone: _____
Cell #: _____	Occupation: _____
Soc. Sec. #: _____	Student: Please Circle YES NO
Birth Date: _____	Student Status: Full Time Part Time
Sex: Male Female	School Name: _____
Marital Status: _____	Address: _____
Single Married Divorced Separated	

Responsible Party Information

Insurance holders information. In case of minor, parent / guardian information.

Primary Insurance Holder

Name: _____
Address: _____
Telephone: _____
Soc. Sec. #: _____
Birth Date: _____
Employer: _____

Secondary Insurance Holder

Name: _____
Address: _____
Telephone: _____
Soc. Sec. #: _____
Birth Date: _____
Employer: _____

Dental Insurance Information

Primary Insurance

Ins. Company: _____
Address: _____
Telephone: _____
Group #: _____
Relationship to Policy Holder:
Self Spouse Minor Other

Secondary Insurance

Ins. Company: _____
Address: _____
Telephone: _____
Group #: _____
Relationship to Policy Holder:
Self Spouse Minor Other

Referral / Physician Information

Referred by: _____
Dentist: _____
Telephone: _____
Physician: _____
Telephone: _____

Medical Insurance Information

Ins. Company: _____
Address: _____
Telephone: _____
Group #: _____

I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Berrios to release all necessary information to secure payment. NOTE: Balances over 45 days old are subject to a 1.5% monthly service charge.

Signature: _____ Date: _____