WELCOME TO DENTAL CARE OF RIALTO

1. Patient's Name (First) _____(MI)____ (Last)_____
Drivers License _____Social Security# _____E-mail _____
Address Street _____ Apt# _____
City _____State _____ Zip Code _____
Telephone (Home) (___)____-_____(Cell)(___)____-_____D.O.B __-___-___Age ___Sex___

2. Employer Name _____ Telephone # (___)____-_____
Address _____ City _____State ___ Zip Code _____

3. Responsible Party _____ Driver license# _____
Relation to Patient _____Social Security #_____
Employer _____Telephone # _____

4. In Case of Emergency Call. Name _____Relationship _____
Telephone (Home) (____) ____-_____ (Work) (___)____-_____(Cell) (___)____-_____
Address _____City _____State _____Zip _____

5. Whom can we thank for referring you to our office? _____

6. Insured Patients Only
Insurance Company Name _____Phone # (____)____-_____
Insured's Name _____ID#_____ Social Security #_____
Birth Date ___-____-_____ Relationship to Patient _____

Are you covered by a second insurance company? Yes or No.
If yes, Insurance Co. _____Telephone# (___)____-_____Social Security#_____
Insured's Name _____ID# _____D.O.B___-____-___

Our office is happy to cooperate with patients covered by dental insurance. As a courtesy, we will fill out and file all necessary forms; however, you will be asked to pay the deductible and your portion of the charges the day of service. We will gladly estimate your coverage, and we need your patient portion while waiting for payment from your insurance company. Remember, it is just an **ESTIMATE**. If, after 45 days, the insurance company has not paid, the balance will be due in full. I agree if any default of the above agreement on my part needs legal action, I shall assume all responsibility for interest, and reasonable attorney fees. I have read and understand the above information.
Print Name _____Signature _____Date ___/___/____

Assignment of Benefits
I hereby authorize _____Insurance Company to make payment directly to **Ned Paniagua DMD** for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on today's date ___/___/____. I hereby represent that I am of legal age and legally competent to make this assignment.
Print Name _____Signature _____Date ___/____/___

7. Non-Insured Patients
Payment for patients without dental insurance is due in full at the time of service, unless specific arrangements are made in advance.

As a convenience we accept cash, check, credit cards, apple pay and we offer Care Credit