SSC1
Updated 9/2022

WELCOME...

To Salida Surgery Center, Dental Group

PATIENT INFORMATION

Patient Name: ____________________ D.O.B.: ____________ MR# ____________
Office Use Only

Patient Social Security #: ____________________ Sex: ☐ Male ☐ Female

Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Status: ☐ Minor ☐ Single ☐ Married **Referred By:** ____________________

RESPONSIBLE PARTY

Name: ____________________

Relationship to Patient: ____________________ D.O.B.: ____________

Driver's License/ ID #: ____________________ Social Security #: ____________

Address: ____________________ City: ____________ Zip: ____________

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________ Subscriber ID#: ____________

Subscriber Name: ____________________ Subscriber D.O.B.: ____________

Employer: ____________ Phone#: ____________ Occupation: ____________

Secondary Insurance Carrier: ____________________ Subscriber ID#: ____________

Employer: ____________ Phone#: ____________ Occupation: ____________

CONTACT INFORMATION

Home Phone#: ____________ Cell Phone#: ____________ Work #: ____________

Email Address: ____________________

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

EMERGENCY CONTACT: Name: ____________________ **Phone:** ____________

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/ or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor/ doctor's group, insurance benefits otherwise payable to me. I understand that my 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.

X____________________ ____________

Signature of Patient/ Parent/ Legal Guardian Date