Adriana Lalinde DDS Inc. - New Patient Form

Monterey
Dental Sleep Medicine

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

The best time to contact me is: ☐ Morning ☐ Mid-Day ☐ Evening on ☐ Home phone ☐ Cell phone ☐ Work phone

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Address: _____City:_____ State: _____ Zip: _____

Date of Birth (M/D/Y): ____ /____ /_____ Gender: ☐M ☐ F Social Security Number (SSN): _____

Height: Feet____ Inches____ Weight (lbs): _____ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone_____

REFERRED BY: _____

Employer Information

Employer: _____ Phone: (___) _____Fax: (___)_____

Address: _____City_____ State: _____Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____ /____ /_____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: _____ Zip _____

Phone: (_____)_____Fax: (_____)_____ Email: _____

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _____ Insured DOB___ /___ /_____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: _____ Zip _____

Phone :(_____)_____ Fax: (_____)_____ Email: _____

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____

ENT: _____ Phone: _____

SLEEP DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

OTHER MD: _____ Phone: _____

OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date:_____