ACCOUNT INFORMATION

Name________________________birthdate__________ e-mail__________

Address____________________________city__________state______zip_____

Phones: home______________work________________cell______________

Employment__________________ address____________________________

Social security #________________________driver's license#______________

Spouse/partner's name______________parent's names, if child__________________

Whom to notify in an emergency_______________________ phone__________

Who referred you to Dr. DeAinza_______________________

Signature of responsible party_________________________date______________

**ACCOUNTS NOT PAID WITHIN 60 DAYS WILL BE CHARGED A MONTHLY FEE

Primary Insurance - Please bring your insurance card with you.
Insured's name______________birthdate____________phone______________
Address____________________________city__________state______zip____
Social security #______________home phone__________work phone__________
Employer____________address______________________________________
Insurance____________address______________________________________
Group #____________phone number__________insurance ID #______________

Secondary Insurance
Insured's name______________birthdate____________phone______________
Address____________________________city__________state______zip____
Social security #______________home phone__________work phone__________
Employer____________address______________________________________
Insurance____________address______________________________________
Group #____________phone number__________insurance ID#______________

** Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If an account is not paid within 90 days of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account.

ASSIGNMENT AND RELEASE: I authorize Dr. David E. DeAinza to release any information required for dental benefits. I hereby authorize my insurance benefits to be paid directly to Dr. David E. DeAinza. I am financially responsible for non-covered services.

SIGNATURE_____________________________ DATE__________________