

Alicia Matayoshi DMD
7807 Baymeadows Rd. E. Suite 304

Patient Information

Patient Name _____ Birth Date _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Gender Male Female Family Status Single Married Divorced Widowed Separated

Patients or Parents Employer _____ Work Phone _____

Preferred method of Contact Phone Home Cell Email E-mail Address _____

Emergency Contact _____ Relation _____ Phone _____

Whom may we thank for your referral? _____

Insurance Information

Name of Insured _____ Relation to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Local Union

Address _____ City _____ State _____ Zip _____

Insurance Company Phone # _____

Secondary Insurance

Name of Insured _____ Relation to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Local Union

Address _____ City _____ State _____ Zip _____

Insurance Company Phone # _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers' and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I recognize and accept responsibility for payment of services not covered by insurance benefits. I understand that I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at the time of service. We accept cash, checks, debit card and most major credit cards, including a dental finance plan. I agree to be responsible for payment of all services on my behalf or my dependents, should the account be referred to an agency or attorney for collection.

The undersigned shall pay reasonable attorney's fees and collection expenses.

PATIENT OR PARENT/GUARDIAN SIGNATURE _____ DATE: _____