*Carla S. Dodge * Eric K. Schmidt * Brian J. Hathcoat * Michael T. Lee*
Alameda Family Dental Practice * 2049 Central Avenue, Alameda, California 94501 * (510) 521-0588

PATIENT INFORMATION RECORD

Patient's Name_____ Date of Birth_____

Home Address_____ City_____ Zip_____

Home Phone#_____ Work Phone#_____

Our office is able to provide your health care information through multimedia communications. Please let us know right away if you get a new phone number.

Cell Phone #_____ ☐ OK to Call ☐ OK to Text

E-Mail Address_____ ☐ OK to Email

Employer_____ Position_____

Spouse's Name_____ Spouse's #_____

Emergency Contact Name_____ Phone #_____

Whom may we thank for referring you to our office?_____

ALL PATIENTS WITH INSURANCE MUST COMPLETE THE FOLLOWING:

Patient or Parent's Primary Insurance	Spouse or Second Party Insurance
Employee_____	Employee_____
Social Security or Insurance ID#_____	Social Security or Insurance ID#_____
Birth Date_____	Birth Date_____
Employer_____	Employer_____
Insurance Company_____	Insurance Company_____
Insurance Phone #_____	Insurance Phone #_____
Policy/Group or Plan #_____	Policy/Group or Plan #_____

I hereby authorize this office to release a full report of the examination, diagnosis, treatment, prognosis, etc, of myself to any referring or other treating physicians or insurance companies. I understand that I am fully responsible for all charges for treatment, regardless of insurance coverage.

SIGNATURE_____ DATE_____

RELATIONSHIP (if not patient)_____