Low Family Dental
3031 W. March Lane, Ste 340E
Stockton, CA 95219

Patient Info

Chart Number: _____

Name: _____ Date: _____

SSN: _____ Birthday: _____ Phone #: _____

Address1: _____ City: _____

Address2: _____ State: _____ Zip: _____

Email: _____ Cell Phone#: _____

Please Check the Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School/College: _____ City: _____ State: _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone: _____

Business Address _____ City: _____ State: _____ Zip: _____

Spouse or Parents/Guardian's Name _____ Phone: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ Phone: _____

Responsible Party

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Email: _____ Cell Phone #: _____

Driver's License #: _____ Birthday: _____ SS# _____

Employer: _____ Work Phone: _____

Is this Person Currently a Patient in our Office? YES NO

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal Check ❑ Credit Card ❑ Visa ❑ MasterCard ❑ I wish to discuss the office's payment policy:

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthday: _____ SSN: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ City: _____ State: _____

Insurance Company Phone # _____

Do You have Any Additional Insurance? YES NO If Yes, Complete the following information bellow

Name of Insured: _____ Relationship to Patient: _____

Birthday: _____ SSN: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ City: _____ State: _____

Insurance Company Phone # _____