



Dental Care OF BOCA RATON

David Kagan, DMD • Rosalmarie Salazar, DMD

Personalized and Comfortable

Thank you for selecting our office! We are committed to providing you with meticulous, state-of-the-art dental care. We hate filling out forms as much as you do, but this information is important in helping us meet your dental needs.

Thank you for your cooperation.

About You

Name: _____
Last First M.I. Mr. Mrs. Ms. Dr.

Preferred Name: _____

Birthdate: ___/___/___ S.S.: _____

Home Address: _____

City State Zip

Single Married Divorced Widowed Separated

Home: _____ Pager/Cell: _____

Work: _____ Ext #: _____

E-mail Address: _____

What is the best method to reach you? _____

Employer: _____ Occupation: _____

Present Dentist: _____ How Long?: _____

Last Visit Date: _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you? _____

Responsible Party Information or Policy Holder Information

Name: _____
Last First M.I. Mr. Mrs. Ms. Dr.

Relationship to Patient: _____

Birthdate: ___/___/___ S.S.: _____

Home Address: _____

City State Zip

Home: _____ Pager/Cell: _____

Work: _____ Ext #: _____

Employer: _____

Dental Insurance Co.: _____ Group #: _____

Insurance Co. Telephone: _____

Emergency Contact Information

Name: _____
Last First M.I. Mr. Mrs. Ms. Dr.

Relationship to Patient: _____

Home: _____ Pager/Cell: _____

Work: _____ Ext #: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

A Dental Insurance Plan is a contract between you and your employer, or plan sponsor. It is designed to share in your dental care costs. It will not cover the total cost of your bill. We are not a participating provider on any plan. If insurance is to cover a portion of my treatment, I understand that I am responsible for whatever the insurance does not cover.

Signature
(Parent or Guardian if patient is a minor)

Date