Smile Center of Los Gatos
GINNYLEE RODERICK, D.D.S.

New Patient Information

Today's Date:_____

Name:_____ I prefer to be called:_____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthdate:____/____/____ Age:_____ Social Security #:_____- _____- _____ Driver's License # _____

Home Address:_____
Street City State Zip

Home Phone#_____ Work Phone#_____ Cell Phone#_____

How would you like your appointments confirmed: Home ☐ Work ☐ Cell ☐ E-mail Address: _____

Whom may we thank for referring you ? _____ Other family member seen by us: _____

Employer:_____ Occupation:_____ How long there?_____

Employer's Address: _____
Street/PO Box City State Zip

Person to contact in case of an emergency: _____
Name Phone#

Neighbor or Relative not living with you

His/Her Name:_____ Relation: _____ Work # _____ Home # _____

Address:_____
Street City State

Spouse Information

His/Her Name:_____ Birthdate:_____/_____/_____ Social Security# _____

Employer:_____ Work# _____ Driver's License# _____

Insurance Information

Primary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone#: (____)_____ Group#(Plan, Local, or Policy#):_____

Insurance Co. Address:_____
Street/PO Box City State Zip

Insured's Name:_____ Insured's Social Security#: _____-_____-_____ Insured's Birthdate: ___/____/____ Relation:_____

Insured's Employer:_____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone#: (____)_____ Group#(Plan, Local, or Policy#):_____

Insurance Co. Address:_____
Street/PO Box City State Zip

Insured's Name:_____ Insured's Social Security#: _____-_____-_____ Insured's Birthdate: ___/____/____ Relation:_____

Insured's Employer:_____ Employer's Address: _____
Street/PO Box City State Zip