Keith Grote, DMD
635 Anderson Rd, Suite 16
Davis CA 95616

PERSONAL INFORMATION

Name: _____ ◯M ◯F Date of birth: _____ Age: _____

Marital status: ◯S ◯M ◯D ◯W Spouse name: _____ DOB: _____

If child or student, parent or guardian name: _____

Place of employment: _____ Occupation: _____

Residence Address: _____

Home phone: _____ Work: _____ Cell: _____

Email: _____

Patient employer: _____ Occupation: _____

Spouse employer: _____ Occupation: _____

If retired, former employer: _____

Person financially responsible for account: _____

Address of accountholder, if different from above: _____

Are you covered by a dental plan? ◯Y ◯N Name of plan: _____ Group #: _____

Who is the subscriber to the plan?

Self SS# _____

Spouse SS# _____

Father SS# _____ DOB: _____

Mother SS# _____ DOB: _____

Signature/acknowledgment section:

I acknowledge receipt of the current Dental Materials Fact sheet.

Signature: _____ **Date:** _____

I acknowledge receipt of office privacy practices as required by the HIPAA.

Signature: _____ **Date:** _____

Dental insurance holders only:

My dentist may give my carrier, or any other carrier, information about my dental condition or treatment, needed to determine benefits."

Signature: _____ **Date:** _____