CARLOS A. PIEDRA
DENTISTRY

5717 SW 75TH STREET
GAINESVILLE, FL 32608
P 352.378.1700 • F 352.260.0970

PATIENT INFORMATION

Today's Date _____/_____/____

Patient's Name_____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called _____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Mobile #

Social Security # _____ E-mail Address _____

Are you a full time student? ☐ Yes ☐ No If yes, School Name _____

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

How did you hear about our office? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *or* ☐ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer_____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

I understand this office may photograph my face and mouth for purpose of documentation in my patient chart. _____ (Initial)
I further grant my permission for this office to use my photographs for purposes of educating other patients, including placing them on our website.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____