# Dr. Arthur B. Montoya

## PATIENT INFORMATION

DATE_____

NAME_____ _____ _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST MI

SOCIAL SECURITY #_____ EMAIL _____

ADDRESS_____ _____ _____ _____ _____
STREET APT# CITY STATE ZIP

BIRTHDATE_____ TELEPHONE_____ _____ _____
HOME WORK CELL

NAME OF EMPLOYER_____-ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT—PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

## INSURANCE INFORMATION

| PRIMARY INSURED | SECONDARY INSURED |
|---|---|
| _____ _____ _____<br>LAST FIRST MI | _____ _____ _____<br>LAST FIRST MI |
| _____ _____ _____ _____<br>STREET CITY STATE ZIP | _____ _____ _____ _____<br>STREET CITY STATE ZIP |
| _____ _____ _____<br>HOME # WORK # CELL | _____ _____ _____<br>HOME # WORK # CELL |
| _____<br>EMAIL | _____<br>EMAIL |
| _____ _____<br>BIRTHDATE RELATION TO PATIENT | _____ _____<br>BIRTHDATE RELATION TO PATIENT |
| _____ _____<br>EMPLOYER DENTAL INS CO. | _____ _____<br>EMPLOYER DENTAL INS CO. |
| _____ _____ _____<br>SS# SUBSCRIBER ID GRP # | _____ _____ _____<br>SS# SUBSCRIBER ID GRP # |

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_____

ADDRESS_____

CITY/STATE/ZIP_____

TELEPHONE #_____

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

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

## AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the tight to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professional by any method, including electronic transfer.

_____ _____
Patient or Responsible Party Date

2610 Trinity Dr. Los Alamos, NM 87544 505-662-5666