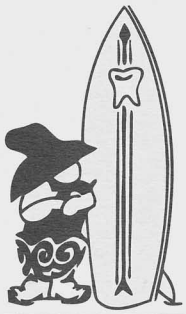

MARTIN R STEIGNER, DDS
RAYMOND A RAMOS, DDS
PEDIATRIC DENTISTRY

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PETALUMA, CA 94954
707•763•1548
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PLEASE COMPLETE OUR INTRODUCTION FORM

Patient's Name_____ Nickname_____
First Middle Last

Sex M☐ F☐ Birthdate_____ School Level _____

Names and ages of brothers and sisters _____

Interests_____ Child's Physician_____

Physician's Address_____ Zip _____

Patient lives with_____

Referral Source_____ Purpose of Visit_____

GENERAL INFORMATION

Father (full name)_____ Date of Birth_____ Marital Status _____

Address_____ ZIP_____

Home Phone_____ Social Security #_____ Driver's License #_____

Employer_____ Cell Phone _____

Address_____ ZIP_____ Work Phone _____

Mother (full name)_____ Date of Birth_____ Marital Status _____

Address_____ ZIP_____

Home Phone_____ Social Security #_____ Driver's License #_____

Employer_____ Cell Phone _____

Address_____ ZIP_____ Work Phone _____

Emergency # _____

Name of person financially responsible for this patient_____

Name of nearest relative not living with you _____

Address_____ Work Phone_____ Home Phone _____

INSURANCE INFORMATION

Do you have dental coverage for this patient?_____ If so, please complete the following:

FATHER Name of insurance Carrier_____ Group/Policy # _____

Billing Address_____ Union/Local_____

MOTHER Name of insurance Carrier_____ Group/Policy # _____

Billing Address_____ Union/Local_____

Assignment of Benefits. *I hereby authorize payment to the above-named dentist of the group dental benefits, otherwise payable to me, but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by my insurance.*

Signature_____ Date _____

Relationship _____