Dr. Jose Luis Osoria, D. D. S.

Implants, Oral Surgery, Endodontics, Orthodontics

Chart # _____

PATIENT

Name: _____ Age_____ Date of Birth_____
Last Name Name
Address _____Apt# _____City _____Zip Code_____

Social Security #_____ Driver's License # _____

Phone #: ( )_____ Cell Phone# ( ) _____e – mail _____ Work Phone # ( )_____

RESPONSIBLE PARTY

Name _____ Age: _____ Date of birth: _____
Last Name Name
Address _____Apt# _____City _____Zip Code_____

Social Security #:_____ Driver's License #: _____ ID _____

Phone #: ( ) _____Cell Phone# ( ) _____ e-mail _____Relationship to Patient: _____

Form of payment: **Cash** **Insurance** **Care Credit**

EMPLOYMENT

Occupation: _____ Employer: _____

Monthly Gross Income _____ How Long? _____

Business Address _____ City_____

Zip Code_____ Business Phone: _____ext #_____

REFERENCES

Name _____
Last Name First Name

Phone # _____

Address _____ Apt # _____

City_____ Zip Code _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name_____ Phone #:_____ Relationship _____
Last Name First Name

GETTING TO KNOW YOU

Are there any other members of your household who are not patients at our office? Yes____ No ____

How did you hear of us? _____

Minor / Child Consent:
I, Being the parent or guardian of _____ do hereby request and authorize the Doctor (s) and/or Staff of this dental office to administer such medications and to perform such diagnostics and therapeutic procedures as may be Necessary for proper dental care as agreed upon through consultation with me. The information, wich appears on these dental and medical histories, is correct to the best of my knowledge.

_____

Patient / Guardian Signature Date

Signature On File
By signing this form, I authorize Dr. Osoria to use this signature as authorization of all my insurance claims submissions. I authorize release of information to all my insurance carriers. I authorize payment to be made directly to Dr. Osoria. I permit a copy of this authorization to be used in place of an original claim form. I understand that I am responsible for my bill and that Dr. Osoria is acting as an agent to help me obtain payment from my insurance carrier.

_____

Patient / Guardian Signature Date