Bernal DENTAL CARE
Yuhao Gao, DDS, Ph.D *3283 Bernal Ave, Ste108, Pleasanton, CA 94566* *(925)249-9242*

PATIENT REGISTRATION

ID:____Chart ID:______
Office Use Only

Patient Information

First Name:__________________________ Last Name:_________________________ Middle Initial:_______________________

Patient is: Responsible Party Policy Holder

Address: _____________________________________City, State, Zip:____

Home Phone:________________________ Work Phone:________________________ Cell Phone:_________________________

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth date:______________________ Social Security #: ____________________________ Drivers Lic#:_______________________

E-mail: ____ I would like to receive email correspondences

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Student Status: Full Time Part Time

Referred By: ____________________________ Name of person or office referring you to our practice: ____

Responsible Party Information

(if someone other than the patient)

First Name:___________________________________ Last Name:__________________________________ Middle Initial:_______________________

Address: _____________________________________Address 2:____

City, State, Zip:____

Home Phone:__________________________________ Work Phone:__________________________________ Cell Phone:_________________________

Birth date:______________________ Social Security #:__________________________ Drivers Lic#:___________________________________

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Insurance Information

Primary:

Name of Insured:_______________________________________ Relationship to Insured: Self Spouse Child Other

Insured Birth date:_____________________________Group #: ____________________________Carrier ID:___________________________

Employer:_____________________________________Address:______________________________City, State, Zip:______________________________

Insurance Company:_____________________________Address: ______________________________City, State, Zip:______________________________

Secondary:

Name of Insured:_______________________________________ Relationship to Insured: Self Spouse Child Other

Insured Birth date:_____________________________Group #: ____________________________Carrier ID:___________________________

Employer:_____________________________________Address:______________________________City, State, Zip:______________________________

Insurance Company:_____________________________Address: ______________________________City, State, Zip:______________________________