

**Alicia Matayoshi DMD**  
**7807 Baymeadows Rd. E. Suite 304**

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Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_ Family Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed

Patients or Parents Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Patients Email:** \_\_\_\_\_

Whom may we thank for your referral: \_\_\_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Union or Local \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Secondary Insurance**

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Union or Local \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I recognize and accept responsibility for payment of services not covered by Insurance benefits. I understand that I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at the time of service. We accept cash, checks, debit card and most major credit cards, including a dental finance plan. I agree to be responsible for payment of all services on my behalf or my dependents, should the account be referred to an agency or attorney for collection.

The undersigned shall pay reasonable attorney's fees and collection expenses.

PATIENT OR PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_