West Dental Care
1127 North Pacific Ave. Glendale, CA 91202 Ph. (818)551-1127 Fax (818)551-1167
PATIENT REGISTRATION

Patient Information Please PRINT clearly. Thank you.

First name: _____Last name: _____Middle Initial: _____

Address: _____Apt. Number :_____

City:_____ State:_____ Zip: _____

Home phone :(_____) _____-_____ Cell: (_____) _____-_____

Email address:_____Driver License #_____

Birth Date: _____ Age: _____ Social Security #: _____

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

Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer:_____ City, State: _____ Work phone: (_____) _____-_____

Student Status: □ Full Time □ Part Time Name of School_____ City, State: _____

Preferred Pharmacy:_____

Physicians Name:_____Phone:_____

Main Dental concern:_____

Do you use a pre-medication prior to dental treatment (Anti-biotic)? _____

How did you find our office? (Referral Source)_____

EMERGENCY CONTACT _____ Phone:(_____) _____-_____

Responsible Party (if someone other than patient)

First name: _____Last name: _____Middle Initial: _____

Address: _____Apt. Number :_____

City:_____ State:_____ Zip: _____

Home phone :(_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____

Birth Date:_____ Soc. Sec: _____ Relationship to Patient:_____

□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Primary Insurance Information (please provide insurance card)

Name of Policy Holder:_____ **Policy Holder Birth Date**:_____

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder SSN-or-**ID #**:_____

Address (if different than patient's):_____

City:_____ State:_____ Zip: _____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____ Address:_____

City:_____ State:_____ Zip: _____

Secondary Insurance Information (please provide insurance card)

Name of Policy Holder:_____ **Policy Holder Birth Date**:_____

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder SSN-or-**ID #**:_____

Address (if different than patient's):_____

City:_____ State:_____ Zip: _____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____ Address:_____

City:_____ State:_____ Zip: _____