

RENE N. DEL ROSARIO, D.D.S.
GRACE LACSON-DEL ROSARIO, D.D.S.

Union Landing Dental Center
32364 Dyer Street
Union City, CA 94587
510.324.2000

Dentistry at Los Olivos
43480 Mission Blvd., Ste 150
Fremont, CA 94539
510.659.8000

Lakeshore Family Dental
35111-A Newark Blvd.
Newark, CA 94560
510.494.0404

Patient Information:

| | | |
|-------------------------------------------------------|-------------------|------------------------------|
| Last Name | First Name | MI |
| Nick Name | Birth Date | Social Security # |
| Address | Street | City State Zip |
| Home Phone | Work Phone | Cellular/Pager Email Address |
| Marital Status (Single, Married, Divorced, Separated) | Student (Yes/No) | Name of School City State |
| Employer | Occupation | |
| Spouse's Name | Spouse's Employer | Spouse's Phone Number |

Dental Insurance Information: (Primary Insured)

| | | |
|---------------------------|-------------|----------------------|
| Last Name | First Name | MI |
| Social Security # | Birth Date | Driver's License # |
| Employer | Occupation | Length of Employment |
| Employer Address | Street | City Sate Zip |
| Insurance Carrier | Group # | |
| Insurance Mailing Address | Telephone # | |

Please list below if you have any other Dental Insurance: (Secondary Coverage)

| | | |
|---------------------------|------------|----------------------|
| Last Name | First Name | MI |
| Social Security # | Birth Date | Driver's License # |
| Employer | Occupation | Length of Employment |
| Employer Address | Street | City Sate Zip |
| Insurance Carrier | Group # | |
| Insurance Mailing Address | Telephone# | |

Referral Information: (Walk in, Web Site, Employee, Co-worker, Friend) _____

I hereby authorized the release of any information including the diagnosis and the records of any treatment, or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled. Authorizations is hereby granted to Equifax and Union Landing Dental Center/ Dentistry at Los Olivos/Lakeshore Family Dental to release information for appropriate credit verification and patient information required.

Signature of Patient/Guardian

Signature of Responsible Party

Date