THOMAS C. JEW, D.D.S.

1394 FRANKLIN STREET
SANTA CLARA, CALIFORNIA 95050

This information is necessary for your health and our records, and will be considered confidential.

PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____ (Circle One) Mr. Dr. Mrs. Ms. Miss Birthdate ____/____/____

Home Phone ( ) _____ Business Phone ( ) _____ Social Security # ___-___-___

Mailing Address _____ City _____ Zip _____

Street Address or Location _____ How long? _____

Previous Address (if less than 3 years at current address) _____

Occupation _____ Patient's Employer _____

Employer's Address _____ City _____ Zip _____

Driver's License # _____ Bank _____

Nearest relative not living with you _____ Relationship _____ Phone ( ) _____

In case of emergency, call _____ Relationship _____ Phone ( ) _____

If patient is a student, name of school _____

Has any member of your family ever been treated in our office? (Circle one) Yes No

FINANCIAL INFORMATION

Person financially responsible (if self, proceed to next section) _____ Relationship _____

Social Security # ___-___-___ Driver's License # _____ Home Phone ( ) _____

Mailing Address _____ City _____ Zip _____

Occupation _____ Employer _____ Business Phone ( ) _____

Employer's Address _____ How long with current employer? _____

FAMILY INFORMATION

Name of spouse or parent (circle one if applicable) _____

Occupation _____ Employer _____ Business Phone ( ) _____

INSURANCE INFORMATION

Are you covered by dental insurance? ☐Yes ☐No If yes, please complete this section.

PRIMARY INSURANCE

Insured's Name _____

SS # ___-___-___ Birthdate ____/____/____

Employer _____

Ins. Co. or Plan _____

Group/Union Name _____

Group or Policy # _____ Local # _____

Date Employed _____

How much is the deductible? _____

SECONDARY INSURANCE ☐ Yes ☐ No

Insured's Name _____

SS # ___-___-___ Birthdate ____/____/____

Employer _____

Ins. Co. or Plan _____

Group/Union Name _____

Group or Policy # _____ Local # _____

Date Employed _____

How much, if any, has been satisfied? _____

Has the patient had any dental care under this plan this year? ☐ Yes ☐ No

CONSENT

The undersigned hereby authorizes the dentist(s) to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist(s) to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist(s) to perform any and all forms of treatment, medication and therapy, that may be indicated, and further authorize and consent that the dentist(s) choose and employ such assistance as is deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements are made in advance. I authorize my insurance carrier to issue the dental benefits of my plan directly to this office. I also authorize release of any information necessary to process dental insurance. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

PLEASE COMPLETE OTHER SIDE