Drs. Cane & Quist

1206 The Alameda, Berkeley, CA 94709
(510) 525-7521 Fax (510) 525-5262

Patient Information

Today's Date: _____ ☐Male ☐Female

NAME: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

Birthdate: ____ / ____ / ____ Age: _____

Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

Hm# (___) _____ Cell/Other #: _____

Wk: (___) _____

E-Mail address: _____

Employer: _____

Employer Address: _____

_____

How long there? _____ Occupation: _____

Name of Spouse / Partner _____

Best time to reach you? Day _____ Night _____

Whom may we thank for referring you? _____

Previous dentist: _____

Last Visit Date: _____

Full time student? ☐ Yes ☐ No

Name of school _____ City _____

Person Responsible for Account

His/Her Name: _____

Employer: _____

Wk: (___) _____ Ext: _____

Birthdate: ____ / ____ Relation: _____

In the event of an emergency, is there someone who lives near you that we should contact

His/Her Name: _____

Wk: (___) _____ Ext: ___ Hm# (___) _____

Relation: _____

Primary Dental Insurance

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone # _____

Group # (plan, local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____

Insured's Employer: _____

I Understand . . .

Your appointment time is reserved ***only*** for you. We do not double book except for emergency patients. If you need to change your appointment, you must notify us one business day in advance (i.e.: To change a Monday appointment you must notify us the previous Friday morning). A fee based on appointment time reserved will be charged for ***late*** cancellations or missed appointments.

Payment in full is required at the time of service. For patients with dental insurance, we will require your copayment and we will bill your insurance company for you. For your convenience we accept personal checks, Visa and Mastercard. Unpaid balances will be billed to your credit card on file.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claim.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity

_____
Signed (patient, or parent if minor) Date