Valerie A. Foster, D.M.D., P.C.

19560 SW Alexander St.
Aloha, Oregon 97006
(503)649-7011

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.

Name:_______________________________________ **Date of Birth:**___ ___________________________ Spouse/ Parent Name:_____________________
Last First Initial

Name Preferred:________________________________ *Spouse/Parent Information:*

If Child, Parent's Name:____________________ Spouse/Parent Name:_______________ ______

Patient/Parent SS#:________________________ Spouse/Parent SS#:________________________

Marital Status (check one): Single___ Married___ Spouse/Parent D.O.B.:____________________ Divorced___ Separated___ Widowed___

Home Address (if different from patient):

Home Address____________________________

______________________________________ ______________________________________

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Employer – Name & Address: ______________________

Phone: Home___________________________ Phone: Home____________________

Work________________ Cell_______________

Work_____________Cell_________________

Employer – Name & Address: ________________ Employer – Name & Address:__________________________

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Email Address:___________________________

______________________________________ **Whom may we thank for this referral:**________

Other family members in this practice:________

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Dental Insurance - Primary **Dental Insurance - Secondary**

Employee Name__________________________ Employee Name_________________________

Date of Birth_____________________________ Date of Birth____________________________

SS#____________________________________

SS#___________________________________

Employer_______________________________

Employer______________________________

Insurance Co.____________________________ Insurance Co.____________________________

Address & Ph. #:________________________ Address & Ph.# _________________________

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Group#___________________________________
Group#_________________________________
ID#_______________________________________
ID#_____________________________________

In Case of Emergency:
Relative to Contact (other than Spouse)________________________Phone________________________
Other Contact (not a relative)________________________________Phone________________________

Please sign and return.
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information, concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits and/or to another dentist.
I acknowledge that I am financially responsible for all charges.
I hereby authorize the doctor to release any and all information necessary to secure payment.
I authorize the payment of insurance benefits directly to Valerie A. Foster, D.M.D, P.C.
Signature____ Date_______________________________