CEDAR VALLEY DENTAL
Pompilia C. Belean, D.D.S.

Patient Information:

Last Name _____ First Name _____ MI ____ Preference _____ Sex: M F

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security _____ Email _____

Marital Status (circle one) S M D W O

Responsible Party:

Last Name _____ First Name _____ Relation to Patient _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security _____ Email _____

Emergency Contact:

Full Name _____ Phone Number _____ Relation to patient _____

Whom may we thank for referring you to our practice? _____

Insurance Information:

Policy Holder Name _____ Insurance Co _____

Employer _____ Insurance Co phone _____

Member ID _____ Group #_____

Is this plan purchased by you individually (not through your employer)? Y or N

_____ I acknowledge that Cedar Valley Dental may share my x-rays, insurance information and dental and/or medical information with my insurance company or any specialist that I may be referred to.

_____ I also acknowledge that I was able to review Cedar Valley Dental's Notice of Privacy Practices.

_____ _____

Patient or Responsible Party Signature Date