Lauren Yasuda Rainey, DDS, Inc.
General Dentistry
2519 Ashby Avenue, Berkeley, CA 94705
www.BerkeleyDentalOffice.com

# New Patient Information

## I. Personal Information.

First Name: _____ Last Name: _____ MI: ____ Nickname: _____

Date of Birth: _____ SSN: _____ *Kept strictly confidentlial; necessary for insurance.*

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

If you weren't referred, how did you hear about us? _____

## II. Contact Information.

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Preferred Phone Number: ☐ Home ☐ Cell ☐ Work

Preferred Contact Method: ☐ Phone ☐ Email ☐ Mail ☐ Text

Emergency Contact: _____ Phone: _____

## III. Responsible Party.

*If someone other than you is the responsible party, please complete the following.*

First Name: _____ Last Name: _____ Date of Birth: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email Address: _____

## IV. Insurance Information.

*If you have dental insurance, please complete the following.*

| | **Primary Dental Coverage** | **Secondary Dental Coverage** |
|---|---|---|
| Name of Subscriber: | | |
| Subscriber ID or SSN: | | |
| Subscriber Date of Birth: | | |
| Relationship to Subscriber: | ☐ Self ☐ Spouse ☐ Dependent | ☐ Self ☐ Spouse ☐ Dependent |
| Subscriber's Employer: | | |
| Insurance Company: | | |
| Insurance Co. Phone: | | |
| Group Name: | | |
| Group Number: | | |