PERIODONTAL ASSOCIATES

Shayna S. Rondon, DDS MS
1171 Murrieta Blvd., Suite 200, Livermore, CA 94550
(925) 449-6633 Fax: (925) 449-0766

Mr. Mrs. Ms. Miss. Date:_____

Patient Name:_____
First MI Last Preferred Name

Address:_____
City Zip

Home Ph:_____ Work Ph:_____ Cell Ph:_____ Preferred Ph: Hm Wk Cl
Is it ok to send you text messages regarding your appointments? YES NO

Date of Birth:_____ SS#:_____ e-mail:_____

Who is legally responsible, if other than patient? _____

Who can we thank for referring you? _____ Name of your general dentist:_____

Name of your employer:_____Position:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: self spouse parent other

Insured SS#: _____ Insured Date of Birth: _____

Employer: _____ Dental Insurance Company: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: self spouse parent other

Insured SS#_____ Insured Date of Birth: _____

Employer:_____ Dental Insurance Company:_____

**** Please provide your photo ID + any dental AND medical insurance cards at time of appointment****

Consent

I hereby authorize Dr. Rondon, or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor, to make a thorough diagnosis of my dental needs.

Patient Name: _____ Date: _____

Parent or responsible party: _____ Relationship: _____