

*Dr. Bruce Bosler*310 Alamo Dr. Ste A2
Vacaville, CA 95688
www.CaliforniaSmiling.com**Patient Information**Date: _____ Home Telephone: _____ Work Telephone: _____
Other Telephone: _____ Email Address: _____**Personal Information:**Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Age: _____
Married Unmarried Other
Employer: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Position: _____
Main Telephone: _____**Spouse/Guardian Information:**Name: _____
Birthdate: _____ Age: _____
Employer: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Work Telephone: _____

Whom may we thank for referring you? _____

General InformationConvenient appointment time: _____ Person responsible for account: _____
Person to contact for emergency: _____ Relationship to patient: _____
Relationship to patient: _____ Driver's License #: _____
Their telephone: _____*If you have dental insurance that you would like for us to bill on your behalf please fill out the following:***Primary Carrier**Name of Insured: _____
Social Security #: _____
Insurance Company: _____
Employer: _____
Member#: _____
Date Employed: _____**Secondary Carrier**Name of Insured: _____
Social Security #: _____
Insurance Company: _____
Employer: _____
Member#: _____
Date Employed: _____

I hereby authorize this dental facility to render necessary dental care. If for any reason I do not have coverage under my dental insurance plan, I understand that I am personally responsible for the value of the services received. I hereby authorize the release of any information acquired during my examination for purposes of dental insurance reimbursement.

Signature of Contractholder, Parent (If under 18) or Guardian_____
Date*Dr. Bruce Bosler*

