Lokesh C. Rao, D.D.S

Welcome Form

PATIENT INFORMATION

HIGHLIGHTED AREAS MUST BE FILLED OUT

NAME _____ DOB _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

EMPLOYED BY _____

EMAIL _____ SSN _____

REFERRED BY _____ LAST DENTAL EXAM _____

CHIEF ORAL COMPLAINT _____

PRIMARY INSURANCE

INSURANCE NAME _____ SUBSCRIBER _____

DOB _____ SSN _____ EMPLOYED BY _____

GROUP NUMBER _____ ID NUMBER _____

RELATION TO PATIENT _____

ADDITIONAL INSURANCE

INSURANCE NAME _____ SUBSCRIBER _____

DOB _____ SSN _____ EMPLOYED BY _____

GROUP NUMBER _____ ID NUMBER _____

RELATION TO PATIENT _____

PHARMACY INFORMATION

NAME OF PHARMACY _____

ADDRESS _____

CITY & STATE _____ ZIPCODE _____ PHONE NUMBER _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE _____ DATE _____