LeJon M. Carreon, D.D.S.
FAMILY DENTISTRY

PATIENT INFORMATION

Name:_____ Sex: ☐ Male ☐ Female
Address:_____ Date of Birth:_____
City/State/Zip:_____ Social Security #:_____
Primary Phone:_____ Home / Work / Cell Marital Status: Married / Single / Divorced / Widowed
Phone:_____ Home / Work / Cell Email address:_____@_____
Referred By:_____

PATIENT EMPLOYMENT ☐ Employed ☐ Retired ☐ Student ☐ Other_____

Employer:_____ Employer Address:_____
Phone:_____ _____

GUARANTOR - Responsible Party (Insured)

☐ Same as Patient:_____
Address:_____
City/State/Zip:_____

GUARANTOR'S EMPLOYMENT INFORMATION

Employer:_____Phone:_____
Social Security #:_____
Date of Birth:_____

PRIMARY INSURANCE ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party:_____ Insurance Company:_____
Relationship to Patient:_____ Insured Social Security #:_____
Insured Phone:_____ Member ID #:_____
Insurance Company Phone:_____ Group #:_____
Insured's Date of Birth:_____

SECONDARY INSURANCE ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party:_____ Insurance Company:_____
Relationship to Patient:_____ Insured Social Security #:_____
Insured Phone:_____ Member ID #:_____
Insurance Company Phone:_____ Group #:_____
Insured's Date of Birth:_____

Assignment of Benefits: I herby assign all dental benefits to LeJon M. Carreon, DDS. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not said insurance company pays. I hereby authorize said assigned to release all information necessary to secure payment.

Signature:_____ Date:_____

I authorize Dr. Carreon to use my photo on social media- YES_____ NO_____
I authorize Dr. Carreon and Staff to leave messages regarding treatment on my: **Home Phone** YES NO **Cell Phone** YES NO