



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 should we contact in an emergency? _____

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: _____

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: _____