SUMMER BREEZE
DENTAL

Dr. Arlene F. Caringal & Associates

REGISTRATION FORM

Date: _____

Name: _____ Date of Birth: _____

(Please Print)

Address: _____

Cell Number: _____ Home: _____

E-mail Address: _____

How did you hear about us? (Please specify) _____

Do you have insurance? YES _____ (If yes, please present your card to the reception)

NO _____

Note: WE DON'T DO DIRECT BILLING TO THE INSURANCE. WE WILL FILE THE CLAIM ON YOUR BEHALF AND INSURANCE WILL PAY YOU ACCORDING TO YOUR BENEFITS.

I certify that the above information is true and correct.

_____

(Signature of Patient / Guardian)

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