Bhavana Thakur D.D.S
281 E. Hamilton Ave Suite #3 Campbell, Ca 95008 (408) 871-0877

Patient information

Patient Name_____ Date of birth_____
☐Male ☐ Female
☐ Single ☐Married ☐Divorced ☐Widowed ☐Partnered
Home Address _____City _____Zip_____
Home Phone _____Cell Phone _____ Work Phone_____
Email Address_____
Social Security # _____ Driver's License_____
Emergency contact name_____ phone # _____
Relationship_____
Who may we thank for referring you? _____
Responsible Party (if patient is a minor) _____
Student? ☐ Full Time ☐Part Time School_____ Location_____

Insurance Information

Name of the Insured_____ Date of birth_____
Patient's Physical Address: _____ City_____ Zip_____

Home Phone _____Cell Phone_____ Work Phone_____
Social Security # OR ID#_____ Driver's License _____
Employer_____ Employment start date_____
Employer Address_____City_____State____ Zip_____
Insurance Company_____ Group #_____ BIC #_____
Insurance Co Address_____ City_____ State___ Zip_____
Insurance Coverage (check all that apply) Self ☐ Spouse ☐ Children ☐ Others ☐
Relationship if "Others" is checked above_____

Secondary Insurance (if none, leave section blank)

Name of the Insured_____ Date of birth_____
Billing Address_____ City_____ Zip_____
Home Phone _____Cell Phone_____ Work Phone_____
Social Security #_____ Driver's License _____
Employer_____ Employment start date_____
Employer Address_____City_____State____ Zip_____
Insurance Company_____ Group #_____ Local #_____
Insurance Co Address_____ City_____ State___ Zip_____
Insurance Coverage (check all that apply) Self ☐ Spouse ☐ Children ☐ Others ☐
Relationship if "Others" is checked above_____

Authorizations, Assignment and Release Signature

I certify that I, and my dependent(s) have insurance coverage with _____
(Name of insurance company)
and I assign directly to Dr. Thakur all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. To the best of my knowledge my medical history information is complete and correct.

Signature_____ _____ _____
Patient, Parent, Guardian, Legal Representative Date Relationship to patient