

James A. Cox, D.D.S. * Cristian Miranda, D.D.S.
777 Welch Road, Suite H * Palo Alto, CA 94304 (650) 326-7257

Please print the following information & complete both sides, Thank You

Patient _____ Birthday _____
Last Name First Middle (Nick Name) Month / Day / Year
Person Responsible for the bill _____ Social Security No. _____

Residence Address _____ Phone () _____
(Best # to reach you)

City _____ State _____ Zip _____ Cell Phone () _____
(Best # to reach you)

E-mail address _____ Please Indicate Preferred Contact Method: _____

Business Address _____ Phone () _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Drivers License _____

Full name of Spouse _____ Contact Number _____

Spouse Employed by _____ Occupation _____

In case of an emergency, closest relative or friend _____
Name Phone #

Referral Source _____

Please give insurance Card to front Desk @ time of check in, Thank you

Dental Insurance Prime Carrier _____ **Ortho Coverage** _____

Dental Insurance Carrier _____ Group # _____

Carrier Address _____ Phone Number: _____

Name of Insured _____ Soc.Sec.No. _____

Birthday of Insured _____ Employer _____ Relationship to Patient _____

Dental Insurance Second Carrier / Dual _____ **Ortho Coverage** _____

2nd Dental Insurance Carrier _____ Group # _____

Carrier Address _____

Name of Insured _____ Soc. Sec No. _____

Birthday of Insured _____ Employer _____ Relationship to Patient _____

Please complete other side, Thank you.

