Dr. Amrit Nehru
Bellflower Family Dental Services
Proudly Serving Bellflower Since 1989

Patient Information

Name: _____ Home Phone: (____) _____-_____
Street Address: _____ Work Phone: (____) _____-_____
City: _____ State: _____ Zip Code: _____ Social Security #: _____-____-_____
Date of Birth: ___/___/___ Marital Status: _____ Driver's License #: _____ Sex: _____
Employer Name: _____ Title: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Referred By: _____ First Visit Date: _____
Dental Insurance Name #1: _____ Dental Group #1: _____
#2 _____ #2: _____

Whose Insurance (circle one): Self Spouse Parents

Spouse or Parent Information

Name: _____ Birthdate: _____/_____/_____
Employer: _____ Phone #: (____) _____-_____
Address: _____ Social Security #: _____-_____-_____
Bank and Branch: _____ Savings: _____ Checking: _____
Bill to be Paid by (circle one): Self Insurance Other: _____

Emergency Contact

Name: _____ Phone #: (____) _____-_____

Acknowledgement and Authority

I consent to treatment as necessary or desirable to the care of the patient named above. Including but not restricted to whatever drugs, performance of operations and conduct of lab, x-ray or other studies that may be used by the attending dentist or his nurse. I also acknowledge full responsibility for the payment of such services and agree to pay them in full AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

_____ _____
Signature (if under 18 legal guardian) Print Name