Date: _____ **Date of Birth**: _____ **Social Security #**: _____

Patient Full Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Contact numbers: Home: _____ Cell Phone: _____ **Relative**: _____

Best time to reach you: _____ day _____ night **Email address**: _____

Gender: Male _____ Female _____ **Age**: _____

◯ Married ◯ Widowed ◯ Single ◯ Separated ◯ Divorced ◯ Life Partner

Student Status: Fulltime _____ Part-time_____ Not a student _____ **Veteran Status**: Yes___ No___

Smoker: Yes____ No____

Emergency Contact Name: _____ **Contact number**: _____

********** **We are required to obtain the following requested information**********

Homeless status: Not homeless _____ Doubling up _____ Shelter ____ Street ___ Transitional ____

Migrant worker: Migrant _____ Not a farm worker _____ Seasonal _____

Language Barrier: Yes ____ No ____ **What is your primary Language Spoken** _____

Race: Native American Indian ___ Native Hawaiian ___ White ___ Asian ___ Black/African American ____

Other Pacific Islander ___ Hispanic ___

Ethnicity: Hispanic/Latino ___ Not Hispanic ___

Primary Care Provider: _____ **Primary Dentist** _____

Primary Insurance Coverage: _____

Subscribers Name: _____ **Relationship to Patient**: _____

Additional Insurance Coverage: _____

Number of family members in household: _____

How did you hear about RBIC? _____

***** **State your household income in one of the following categories listed below*****

Household income: Weekly _____ Biweekly _____ Monthly _____ Yearly _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangement have been made in advance with our Patient Financial Department. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

Patient Signature	Date	Signature of guardian if patient is under 18 years