



# TANEGADENTAL

**Dr. Janet Repane Tanega**  
124 Hazelwood Dr.  
South San Francisco, CA 94080  
Phone: 650-794-0203

## Patient Registration

Please complete the following confidential information.

Patient's Name: \_\_\_\_\_

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss \_\_\_ Dr. \_\_\_ Other \_\_\_

Name you prefer to be address by:  
\_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Length of Employment: \_\_\_ Mos./Yrs. Occupation: \_\_\_\_\_

If patient is a child, Parent's Name: \_\_\_\_\_

School's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Full Time Student: Yes \_\_\_ No \_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_

Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Other \_\_\_

Person to contact in case of an emergency:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Alternate Phone: ( ) \_\_\_\_\_

Name of Person Responsible for this Account: \_\_\_\_\_

*Please complete the following information in full if you would like us to assist you with your insurance claims.*

Primary Dental Insurance Company: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_ Subscriber is: Self \_\_\_ Spouse \_\_\_

Secondary Dental Insurance Company: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber is: Self \_\_\_ Spouse \_\_\_

Medical Insurance Company: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber is: Self \_\_\_ Spouse \_\_\_

*If the insurance coverage is through your spouse, please provide us with Spouse's Name:* \_\_\_\_\_

Spouse's Employer Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ext.: \_\_\_\_\_

Spouse's Employer Address: \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_

Spouse's Birth Date: \_\_\_\_\_

How did you hear about our office? (Please circle): Banner Flyer Internet Website Yellow Pages Patient Doctor Other

Whom may we thank for referring you to us? \_\_\_\_\_

I hereby authorize the release of any information required to complete my insurance claims and further authorize payment directly to Tanega Professional Dental Corp. for any benefits otherwise payable to me for their professional services. A copy of this authorization may be used in place of the original. To avoid misunderstanding regarding insurances, we wish our patients to know that all services rendered are charged directly to the patient and that the patient is **responsible for all fees not paid by the insurance company.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient/Responsible party)