Cecile Sebastian, D.D.S.
Excellence in Comprehensive Dentistry

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ____/_____/_____SSN# _____ E-mail _____@_____

Spouse's Name _____ Cell # (_____) _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____ City _____ State _____ Zip _____

Hm# (___)_____

Cell# (____) _____

Wk# (___)_____

DOB: ____/_____/_____

SSN# _____

Relationship: _____

YOUR PREFERENCES

Do you prefer to receive calls from our office at:[ ] Home [ ] Work [ ] Cell

Who may we thank for referring you?

Patient _____ Ad(Newspaper/Magazine) _____

Internet _____ Doctor _____

How do you wish to be addressed by our staff?

_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

CONFIDENTIAL

Pauahi Tower, Suite #340
1003 Bishop Street | Honolulu, HI 96813
Tel: (808) 537-2880 | Fax: (808) 537-1553
www.hawaiiansmile.com