## *Patient Information*

(This information is necessary for our files and your health and will be considered CONFIDENTIAL)

Patient's Name . . . . . Age . . . . . Your date of birth . . . . . .

Residence Address . . . . . City . . . . . Zip . . . . . .

**Home Phone # (_____)** . . . . . **. Cell Phone # (_____)** . . . . . **SS #:** . . . . . .

**E-MAIL ADDRESS** . . . . . .

☐ Married ☐ Single ☐ Separated ☐ Widowed Spouse's Name . . . . . .

Employed by . . . . . Occupation . . . . . .

Business Address . . . . . Bus. Phone . . . . . .

Spouse Employed by . . . . . Occupation . . . . . .

Business Address . . . . . Bus. Phone . . . . . .

Name of nearest relative not living with you . . . . . Relationship . . . . . .

Complete Address . . . . . Res. Phone . . . . . .

Name of Physician. . . . . Address. . . . . Phone . . . . . .

Specialty . . . . . .

Name of Dentist . . . . . Address. . . . . Phone . . . . . .

How Long? . . . . . .

Purpose of Appointment. . . . . .

Referred by . . . . . .

## FINANCIAL INFORMATION (ALSO NECESSARY FOR INSURANCE PROCESSING)

Person responsible for this account. . . . . Relationship . . . . . .

**RESPONSIBLE PERSON'S SS#** . . . . . **AND BIRTH DATE** . . . . . .

Address. . . . . Phone . . . . . .

**Dental Insurance (Name of Co.) (Primary)** . . . . . .

Insurance Group No. . . . . .

.Soc. Sec. No. of Insured . . . . . .

**Dental Insurance (Name of Co.) (Secondary)** . . . . . .

Insurance Group No. . . . . .

Soc. Sec. No. of Insured . . . . . .

## INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that **ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.** We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Patients will be responsible for any cost incurred in collection of a delinquent account. Each fee is individual for the individual patient.

## APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once an appointment is made, please remember this time is reserved for you; **AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE CANCELLATION CHARGE MAY BE MADE.**

**CONSENT FOR EXAMINATION:** I hereby grant authority to Dr. Lu to examine and perform such diagnostic procedures (including radiographs) as he deems necessary or advisable and **to share these findings with my referring doctor(s) and insurance companies (to process my claim(s))**.

Signed . . . . . Date: . . . . . .

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

Relationship . . . . . .

**PLEASE COMPLETE BOTH SIDES**

4-18-12