

**PATIENT INFORMATION**

NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Married  Single  Minor  Male  Female

ADDRESS \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SSN# \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-MAIL \_\_\_\_\_

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

IF STUDENT, SCHOOL NAME \_\_\_\_\_

REFERRED BY \_\_\_\_\_

*Whom may we thank for referring you to our office?*

Insurance  Publication  Internet  Other

**ACCOUNT INFORMATION**

*Person Responsible for Account:*

NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Patient  Parent  Guardian  Spouse

ADDRESS \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SSN# \_\_\_\_\_

PHONE (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-MAIL \_\_\_\_\_

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

**INSURANCE INFORMATION**

*Primary Insured*

CARRIER \_\_\_\_\_

*Secondary Insured*

CARRIER \_\_\_\_\_

POLICYHOLDER \_\_\_\_\_

POLICYHOLDER \_\_\_\_\_

MEMBERSHIP # \_\_\_\_\_

MEMBERSHIP # \_\_\_\_\_

GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

SSN# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SSN# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

**AUTHORIZATION**

I hereby grant permission to Dr. Cheung and/or the attending dentist on his staff to perform all procedures and diagnostic tests which he/she deems necessary for the therapeutic treatment of lesions associated with the oral cavity. These accepted techniques might possibly include x-rays, the administration of medicines, anesthetics and dental surgical procedures. If patient is a minor, the parent or guardian must complete all forms before active treatment is initiated (please state the relationship to the child).

SIGNATURE \_\_\_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_

PHONE (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

DATE \_\_\_\_\_