

CONFIDENTIAL

Patient Name: _____ Date of Birth: _____ SS#/SIN: _____
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Work: (____) _____
 Check appropriate Box: Single Married Divorced Other
 If Patient is a minor, name of person(s) with Patient at exam: _____ Relationship to Patient: _____
 If Patient is a minor, Custodial Parent/Legal Guardian: _____
 How did you hear about our office? Insurance Yellow Pages Friend Relative Employee Online
 Whom may we thank for referring you? _____
 Person to contact in case of emergency _____ Phone: (____) _____

RESPONSIBLE PARTY

Person Responsible for this Account: _____ Relationship to patient: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (____) _____ Alternate Phone (____) _____
 Social Security Number: _____ Date of Birth: _____ Employer: _____
 Full payment is due at time of service. For your convenience, we offer the following methods of payment. Please check the option you prefer: Cash Visa Master Card Discover American Express Care Credit

PRIMARY DENTAL INSURANCE

Subscriber: _____
 Name of Plan: _____
 Group # _____ ID# _____
 Insurance Phone (____) _____
 Employer Phone (____) _____
 Occupation: _____
 Date of Birth: _____ SS# _____

SECONDARY INSURANCE

Subscriber: _____
 Name of Plan: _____
 Group # _____ ID# _____
 Insurance Phone (____) _____
 Employer Phone (____) _____
 Occupation: _____
 Date of Birth: _____ SS# _____

Minor/Child Consent:

I, being the parent or guardian of _____ do hereby request and authorize the doctor(s) and/or staff of this dental office to administer such medication and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care, as agreed upon through consultation with me. The information, which appears on these dental and medical histories, is correct to the best of my knowledge.

 Patient/Guardian Signature

 Date

Signature on File

By signing this form, I authorize Allan S. Szeto, D.M.D. to use this signature as authorization of all my insurance claims submissions. I authorize release of information to all my insurance carriers. I authorize payment to be made directly to Allan S. Szeto, D.M.D. I permit a copy of this authorization to be used in place of an original claim form. I understand that I am responsible for my bill and that Allan S. Szeto, D.M.D is acting as an agent to help me obtain payment from my insurance carrier.

 Patient/Guardian Signature

 Date