DENTAL REGISTRATION

Patient Information

Date

Name

Address

City State Zip Code

(___)_____ (___)_____
Mobile Phone Number Work Phone Number

(___)_____ _____@_____
Home Phone Number Email address

□ M □ F _____ _____
Age Birthdate

Employer/Occupation

Employer Address

(___)_____
Employer Phone Number

Insurance Information

Who is responsible for this account?

Relationship to Patient

Insurance Company

Subscriber's Name and Number

Subscriber's Birthdate

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Chyong-Ying (Lisa) Shirai all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

Emergency Contact Information

In case of emergency, contact

Name

Relationship

(___)_____
Phone Number

Name

Relationship

(___)_____
Phone Number