PATIENT REGISTRATION

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us — we will be happy to help.

Patient Information (CONFIDENTIAL)

Date: ____________________

Name ____________________ *Birthdate* ____________ *Home Phone* ____________

Email ____________________ *Cell Phone* ____________ *OK to call Cell?* ☐ *Yes* ☐ *No*

Soc. Sec. # ____________________ *Sex:* ☐ *Male* ☐ *Female*

Address ____________________ *City* ____________ *State* ______ *Zip* ______

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Patient's Employer ____________________ *Work Phone* ____________

Business Address ____________________ *City* ____________ *State* ______ *Zip* ______

Spouse's or Parent's Name ____________________

Spouse's or Parent's Employer ____________________ *Work Phone* ____________

If Patient is a Student, Name of School / College ____________________

Address ____________________ *City* ____________ *State* ______ *Zip* ______

Whom may we thank for referring you? ____________________

Person to contact in case of emergency? ____________________ *Phone* ____________

Responsible Party (IF PATIENT IS A MINOR)

Name of Person Responsible for this Account ____________________ *Relationship to Patient* ____________

Address ____________________ *Home Phone* ____________

Driver's License ____________ *Birthdate* ____________ *Soc. Sec. #* ____________

Employer ____________________ *Work Phone* ____________

Is this person currently a patient in our office? ☐ *Yes* ☐ *No*

Insurance Information

Name of Insured ____________________ *Relationship to Patient* ____________

Birthdate ____________ *Soc. Sec. #* ____________ *Date Employed* ____________

Employer ____________________ *Work Phone* ____________

Employer's Address ____________________ *City* ____________ *State* ______ *Zip* ______

Insurance Company ____________ *Group #* ____________ *Union or Local #* ____________

Ins. Co. Address ____________________ *City* ____________ *State* ______ *Zip* ______

How much is your deductible? ____________ *How much have you used?* ____________ *Max. Annual Benefit* ____________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING*

Name of Insured ____________________ *Relationship to Patient* ____________

Birthdate ____________ *Soc. Sec. #* ____________ *Date Employed* ____________

Employer ____________________ *Work Phone* ____________

Employer's Address ____________________ *City* ____________ *State* ______ *Zip* ______

Insurance Company ____________ *Group #* ____________ *Union or Local #* ____________

Ins. Co. Address ____________________ *City* ____________ *State* ______ *Zip* ______

How much is your deductible? ____________ *How much have you used?* ____________ *Max. Annual Benefit* ____________

Over Please

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name)________________________________'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedative and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

The appointment schedule is maintained to respect the time and convenience of our patients, as well as their emergency needs. Prompt arrival is greatly appreciated. No charge is made for broken appointments provided 48 hours advance notice is given. There will be a $25.00 fee charged if appointments are missed, or cancelled, without 48 hours notice. This fee is the responsibility of the patient. Insurance companies will not pay for broken appointments.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient____________________________________ Date________ Witness ______________________________________

Parent or Responsible Party ______________________________________ Relationship to Patient___________________

*As a courtesy to our **INSURANCE PATIENTS**, we will bill your insurance company for you and estimate your share to be paid at the time of your visit. Please be advised that this is only an estimate. You are responsible for what your insurance company doesn't pay. It is also your responsibility to have knowledge of your policy. If there is a credit after your insurance pays, we will send you a refund. If there is a balance due after your claim has been paid, a statement will be mailed to you. Prompt payment is greatly appreciated. Please keep in mind insurance companies have a maximum they'll pay each year. This maximum may be met by visiting one or more offices. We will be happy to advise you, so do not hesitate to ask if you are concerned about your benefits.*

***Authorization Release:** I hereby authorize my insurance benefits to be paid directly to Dr. Billy Liang. I realize I am financially responsible for **all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions. I grant permission to contact my physicians and/or school to assist in my care.*

____ ________________________

Patient/Parent/Guardian Signature *Date*

*I have received a copy of the **Dental Material Fact Sheet** and a copy of this office's **Notice of Privacy Practices**, as required by law.*

____ ________________________

Patient/Parent/Guardian Signature *Date*