Robert Wong, DDS

WELCOME TO OUR OFFICE!

Please complete the following *confidential* information:

Kanako Shimizu, DMD

Date_____

Patient's Name_____ Birthdate_____ M____ F____
Last First Middle

If patient is a minor, name of parent or legal guardian_____ Relationship_____

Residence Address_____ Res. Phone_____
Street

_____ Cell Phone_____
City State ZIP

E-mail_____ Social Security No._____ Driver License No._____ State____

Patient is: ____minor ____single ____married ____separated ____divorced ____widowed

Your or your parent's employer_____ Occupation_____ Date Employed_____

Business Address_____ Bus. Phone_____
Street City ZIP

If student, name of school_____ Grade_____ FT_____ PT_____

Spouse's Name_____ Employed by_____ Bus. Phone_____

Nearest relative not living with you_____ Relationship_____ Phone_____

Person to contact in case of emergency_____ Phone_____

Is another family member or relative a patient at our office? (name)_____

_____

Whom may we thank for referring you to us?_____

FINANCIAL INFORMATION

Person responsible for this account_____

Address (if different from above)_____ Phone_____

Primary Insurance Co._____ Name of Group Dental Plan_____

Insured person's name_____ SS#_____ DOB_____

Employee No._____ Group No._____ Plan No._____ Union_____

Secondary Insurance Co._____ Name of Group Dental Plan_____

Insured person's name_____ SS#_____ DOB_____

Employee No._____ Group No._____ Plan No._____ Union_____

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 1.5% late charge (18% APR) may be added to my account. I understand that a $10 charge will be applied for returned checks. Init._____

I authorize: 1) use of this signature on all my insurance submission, 2) release of information to all my insurance carriers, 3) my doctor to act as my agent in helping me obtain payment from my insurance carriers, 4) payment directly to my doctor, and 5) a copy of this authorization to be used in place of the original.

Signature_____ Date_____