A Dental Place, LTD
Dan Fong, DDS

Patient's Name _____**Date of Birth** _____

If a Child, Parent/Guardian's Name _____

⌑ Male ⌑ Female Social Security No _____ Marital Status _____

Address: _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____Cell Phone _____Work Phone _____

Email _____ Drivers License No _____

Employer _____Occupation _____

Who may we thank for the referral _____

Someone to notify in case of emergency _____Phone _____

DENTAL INSURANCE INFORMATION

Primary Insurance Information

Insured's Name _____ Date of Birth _____

Employer _____

Name of Insurance Co. _____ Phone No _____

ID No/ SSN _____ Group No _____

Secondary Insurance Information

Insured's Name _____Date of Birth _____

Employer _____

Name of Insurance Co. _____Phone No _____

ID No/ SSN _____ Group No _____

CONSENT

I give consent to the diagnostic procedures and treatment by Dr. Fong necessary for proper dental care.

I give consent for Dr. Fong's use and disclosure of my records (or my child's record) to carry out treatment and to obtain payment.

I authorize payment directly to Dr. Fong of insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for paying the account in full.

To the best of my knowledge the provided information on this page is true and accurate. If there is a change I will contact Dr. Fong with the new information.

_____ _____
(Signature of Patient/Parent or Guardian) (Date)

I acknowledge that the HIPAA Privacy Act Practice protects my privacy and no information (dental, medical or financial) will be shared without my permission. _____
(Initials)

REGISTRATION

OFFICE OF DAN FONG, DDS