PATIENT REGISTRATION

Patients name:_____Preferred Name:_____
Date of Birth:___/___/___ Age:_____ Sex: □Male □Female
Patient is: □Minor □Single □Married □Divorced □Separated
Address_____
City_____State _____Zip_____
Home Phone (____)_____
Cell Phone (____)_____ Other Phone (____)_____
Email Address_____
Patient Employed by:_____
Work Phone (____)_____May we contact you at work? □ Yes □No
Emergency Contact_____Relationship _____Home Phone (____)_____
Whom may we thank for referring you?_____

If patient is a Minor

Father's Full Name _____
SS# _____
Phone (____)_____
Address _____
City, State, Zip _____
Date of Birth _____ /_____ /_____
Employed By_____
Business Phone (____)_____

Mother's Full Name _____
SS# _____
Phone (____)_____
Address _____
City, State, Zip _____
Date of Birth_____/_____/_____
Employed By_____
Business Phone (____)_____

Marital Status:
□Single□Married□Separated□Divorced□Other

□Single□Married□Separated□Divorced□Other

Child lives with: □Both Parents □Mother □Father □Joint Custody □Other Guardian

All office correspondence will go to the address where the child resides.

For Patients Covered by Dental Insurance

Primary Insurance _____	Secondary Insurance_____
Employee Name_____	Employee Name _____
Date of Birth_____	Date of Birth _____
SS# or ID#_____	SS# or ID#_____
Employer Name_____	Employer Name_____
Relationship to Patient_____	Relationship to Patient_____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file. I authorize release of information relating to all insurance claims. I hereby authorize payment directly to Dr. Karen Yee-Lo, and/or Dr. John C. Lo.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We reserve the right to charge for each appointment cancelled or broken without 24 hours advance notice.

Signature_____Date_____