

KEVIN CHANG DDS, INC.

FAMILY AND COSMETIC DENTISTRY

Patient Information (Confidential)

Name: _____ Date: _____

LAST

FIRST

MI

Preferred Name/Nickname: _____ ☐ Male ☐ Female

Birthday: _____ SSN: _____ ☐ Married ☐ Single ☐ Divorced

Month/Day/Year

Address: _____

STREET

APT #

CITY

STATE

ZIP

Employer: _____ Email: _____

Phone Number: _____ Text Communication: ☐ Yes ☐ No

Full Time Student: ☐ Yes ☐ No School Name: _____ Grade: _____

Who may we thank for referring you? _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Responsible Party

Name of Person Responsible for Account: _____ Relationship: _____

Drivers License #: _____ Birthday: _____ SSN: _____

Address: _____

Employer: _____ Work Phone: _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Payment in full is expected at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card (Visa/MC/Discover) ☐ I wish to discuss any payment policy/options

Insurance Information

Name of Subscriber: _____ Relationship: _____

LAST

FIRST

MI

Birthday: _____ SSN: _____ Employer: _____

Insurance Company: _____ Insurance Company Phone #: _____

Member ID: _____ Group #: _____

Do you have any additional Dental Coverage? ☐ Yes ☐ No If Yes, Please

List: _____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature of Patient or Responsible Party

Date