WELCOME!

Kevin Chang DDS, Inc.
1212 Coloma Way #C
Roseville, CA 95661

Patient Information (Confidential)

Name________________________________ Date____________
LAST FIRST MI

Peferred Name/ Nickame ________________________________ ☐ Male ☐ Female

Birthday______________ SS#______________ ☐ Married ☐ Single ☐ Minor
MONTH DAY YEAR

Address________________________________
STREET APT.# CITY STATE ZIP

Employer______________ Telephone________________________________
HOME# CELL# WORK#

Email:______________

Full Time Student ☐Yes ☐No ♦ School Name______________ Grade_______

Who may we Thank for Referring you?______________

Person to contact in case of emergency______________Phone______________Relationship__________

Responsible Party

Name of person responsible for this account______________Relationship__________

Address________________________________HomePhone__________
STREET APT.# CITY STATE ZIP

Drivers License #______________Birthday ______________
MONTH DAY YEAR

Employer______________Work Phone______________SS#__________

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__________

Birthday______________ Member ID/SS#______________
MONTH DAY YEAR

Name of Employer______________ Union or Local#__________

Insurance Company Name______________ Group#__________

Insurance Company/Customer Service Phone______________

DO YOU HAVE ANY ADDITIONAL INSURANCE COVERAGE? ☐Yes ☐No If Yes, Please Complete the Following:

Name of Subscriber______________Relationship__________

Birthday______________ Member ID/SS#______________
MONTH DAY YEAR

Name of Employer______________ Union or Local#__________

Insurance Company Name______________ Group#__________

Insurance Company/Customer Service Phone______________

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