DENTAL REGISTRATION AND HISTORY

Alan S. Lee, D.D.S.

Date________________________

PATIENT INFORMATION

Name____Social Security #___________________________

Address____

City____State_______________________Zip__________________

Sex M F Age________Birthdate__________________________ Single Married Widowed

Divorced Separated Minor

Employer/School____Occupation______________________

Employer/School Address____Employer Phone___________________

Whom may we thank for referring you?____

Reason for Today's Visit____

Former Dentist____Address_________________________________

Date of last dental care___________________________________Date of last dental X-rays_________________________

CONTACTS

Home_____________________________Work_____________________________Cell______________________________

Email Address____

What is the best way to contact you? Email Text Cell Work Home

IN CASE OF EMERGENCY, CONTACT:

Name____Relationship________________Phone______________________

DENTAL INSURANCE

Person responsible for Account____

Relationship to Patient____Phone_______________________

Insurance Co.____Group #_____________________

Is patient covered by additional insurance? Yes No Subscriber's Name_______________________________

Relationship to Patient____________________________Birthdate_____________Social Security #__________________

Insurance Co.____Group #_____________________

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____Date______________________________