PATIENT NUMBER
Office Use Only

MED ALERT BOX
Office Use Only

Dental Practice of Vang (Peter) Ly, D.D.S.

PATIENT INFORMATION:

DATE: _____________ **Social Security #:** ____________________________ **Email:**_______________________

Last Name First Name MI Age Date of Birth

Address: Number Street City State Zip

Home Phone Cell Phone Work Phone

Check Appropriate Box: ☐ Minor ☐Single ☐Married ☐Divorced ☐ Widowed ☐ Separated

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Spouse or Parent's Name Employer Work Phone

If Student, Name of School/College: _________________________City_____________ State______☐ Full T ☐ Part T

In case of an emergency, contact (name and phone #):____

Whom May We Thank For Referring You?____

Responsible Party:

Name of Person Responsible for this Account_________________________________

Relationship to Patient____

Address Home Phone Cell Phone

Driver's License # Birthday Social Security Number

Financial Institution Employer Work Phone

Is this Person Currently a Patient in our Office? Yes ☐ No ☐

*Please Pay Payment in Full at each Appointment.**

Insurance Information

Name of Insured			Relationship to Patient
Birthdate	**Social Security #**		**Date Employed**
Name of Employer	**Union or Local #**		**Work Phone**
Address of Employer	**City**	**State**	**Zip**
Insurance Company		**Group #**	**Policy/ID #**
Ins. Co. Address	**City**	**State**	**Zip**

How Much is your Deductible?________________ How much have you used?_______________ Max Annual Benefit____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐***YES*** ☐***NO*** ***IF YES, COMPLETE THE FOLLOWING:***

Name of Insured			Relationship to Patient
Birthdate	**Social Security #**		**Date Employed**
Name of Employer	**Union or Local #**		**Work Phone**
Address of Employer	**City**	**State**	**Zip**
Insurance Company		**Group #**	**Policy/ID #**
Ins. Co. Address	**City**	**State**	**Zip**

How Much is your Deductible?________________ How much have you used?_______________ Max Annual Benefit____________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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.

X____

Signature of Patient (or Parent if Minor)