PATIENT INFORMATION (please print)

Date:_____

Name: _____ _____
Last First MI

Social Security Number: _____-_____-_____ Birth date: _____/_____/_____ Sex: M/F

Address: _____ City:_____ State:_____ Zip: _____

Phone Numbers: Home: (_____) _____Work: (_____)_____Cell Phone: (_____)_____

Email Address: _____

WHAT IS THE BEST WAY(S) TO CONTACT YOU TO CONFIRM OR SCHEDULE APPOINTMENTS?
☐ E-mail ☐ Home ☐ Work ☐ Cell phone ☐ Text Message

Who may we thank for referring you to our office?_____

In case of emergency, whom should we contact? _____ Phone: (_____)_____

Is Patient a Minor? □ YES □ NO If yes, please fill in information below.
Patient/Guardian Information:
Name: _____ Relationship to patient:_____

Address:_____City:_____ State: _____zip:_____

Home: _____Cell: _____ Work:_____

PRIMARY DENTAL INSURANCE

Name of Subscriber: _____

Relation to Patient:_____Birthdate_____/_____/_____

SS # _____-_____-_____ or
ID#_____

Employer: _____

InsuranceCo:_____

Group #: _____

Insurance Co. Address:_____

City:_____State:_____Zip:_____

SECONDARY DENTAL INSURANCE

Name of Subscriber: _____

Relation to Patient: _____ Birth date_____/_____/___

SS # _____-_____-_____ or
ID#_____

Employer: _____

Insurance Co:_____

Group #: _____

Insurance Co. Address: _____

City: _____State: _____Zip:_____

Continue on next page

MEDICAL INSURANCE

Name of Subscriber: _____

Relation to Patient:_____Birthdate_____/_____/_____

SS # _____-_____-_____ or
ID#_____

Employer: _____

InsuranceCo:_____

Group #: _____

Insurance Co. Address:_____

City:_____State:_____Zip:_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Alex H. Kang DDS, MSD, PLLC for all insurance benefits otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents I authorize the above dentist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ _____**Date:** _____/_____/_____