PATIENT INFORMATION (please print) **Date:** ________________________

Name: ____
Last First MI

Preferred Name or Nickname: _____________________________

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

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: _________________________

Relationship to Patient: ______________

Subscriber Birthdate: _____/_____/____

SS # ________-_______-_______ or

ID#____________________

Employer: __________________________________

Insurance Co: _______________________________

Group #: _______________________

Insurance Co. Address: ____________________________

City: _________________ State: _______ Zip: __________

Insurance Co Phone #:
(_______) ________________________________

SECONDARY DENTAL INSURANCE

Name of Subscriber: _________________________

Relationship to Patient: ______________

Subscriber Birthdate: _____/_____/____

SS # ________-_______-_______ or

ID#____________________

Employer: __________________________________

Insurance Co: _______________________________

Group #: _______________________

Insurance Co. Address: ___________________________

City: _________________ State: _______ Zip: _________

Insurance Co Phone #:
(_______) ________________________________

Continued on next page

MEDICAL INSURANCE

Name of Subscriber: _________________________

Relationship to Patient: ______________

Subscriber Birthdate: _____/_____/____

SS # ________-_______-_______ or

ID#____________________

Employer: __________________________________

Insurance Co: _______________________________

Group #: _______________________

Insurance Co. Address: ____________________________

City: _________________ State: _______ Zip: _________

Insurance Co Phone #:

(_______) ________________________________

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: _____/______/______