

Patient Registration - Welcome to the Office of Dr. Perry Woo

Date _____

Patients Name _____ How do you prefer to be addressed _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: M F Age: _____ Birth date ____ / ____ / ____ Single Married Widow Separated Divorced SS# _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell/other (____) _____

Occupation: _____ Employer _____

Employers Address: _____ City _____ State _____ Zip _____

If Student, name of School/College: _____ Full or Part Time _____

School address: _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office: _____

RESPONSIBLE PARTY

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise please skip to the section titled "Insurance Information"

Name of Responsible Party: _____ Relationship to Patient: _____

Mailing Address: _____ City _____ State _____ Zip _____

Sex: M F Age: _____ Birth date ____ / ____ / ____ Single/Married/Widow/Separated/Divorced SS# _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell/other (____) _____

Occupation: _____ Employer _____

Employers Address: _____ City _____ State _____ Zip _____

If Student please Name School/College: _____ Full or Part Time? _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Patient: _____ SS # _____

Name of Employer: _____ Birth date ____ / ____ / ____

Insurance Co. _____ Insurance Phone # (____) _____ Group # _____

Address: _____ City _____ State _____ Zip _____

Secondary Insurance Information

Policy Holder's Name: _____ Relationship to Patient _____ SS # _____

Name of Employer: _____ Birth date ____ / ____ / ____

Insurance Co. _____ Insurance Phone # (____) _____ Group # _____

Address: _____ City _____ State _____ Zip _____

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 payers 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, or my dependent's behalf.

X _____ Date: _____
Signature of patient or guardian