PATIENT REGISTRATION

Please complete the following confidential information

Date		You Were Referred To Us By			
Last Name		First		M.I.	
Address			Home Phone No.		Work
City	State, Zip		Cell Phone No.		Email
Birthday	Age	Male / Female	Single	Married	Other
Social Security Number		Driver's License Number		Occupation	
Employer / Company Name				Phone No.	
Address					
Person Financially Responsible For This Account				Relationship To Patient	
Address			Home Phone No.		Work
City	State, Zip		Cell		Email
Person To Contact For Emergency			Relationship To Patient		Contact Phone No.

Primary Dental Insurance Company		Secondary Dental Insurance Company	
Phone No.	Group No.	Phone No.	Group No.
Subscriber's Name		Subscriber's Name	
Date of Birth	Relationship To Patient	Date of Birth	Relationship To Patient
Subscriber's Insurance I.D. Number		Subscriber's Insurance I.D. Number	
Subscriber's Social Security Number		Subscriber's Social Security Number	

Authorization To Provide Dental Treatment To Minor (if applicable)

My signature below indicates that I authorize Dr. Ka-Wing Chew and/or his associates to render any and all dental treatment for the above named patient. I understand I am financially responsible for any and all treatment rendered. This authorization remains in effect until the 18th birthday of the patient or revoked by the above named guardian in writing.

Signature of Parent/Guardian _____ Date _____

KA-WING CHEW, D.D.S.

Richmond Neighborhood Family Dental

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(415) 221-8100

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