YOON H. CHANG, DDS, MS

Patient's Name: First ____________________________ Last __________________________ ____________

Gender: M F DOB _____/______/______ Age: ________ Social Security Number:________________________ ________

Home Address: ____

Phone (_______)________________________ Text (yes, No) Email:____________________________________

School Attending: _________________________ Hobbies/Interests: ______________________________________

Occupation: ___________________________________ Work Phone: (______)_____________________________ ___

Name of family dentist: ____

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

<Account Responsible Party>

First Name: ____ Last Name: _________________________________

Gender: M F Relationship with patient: _______________ DOB: ______/_____ /_____ SSN: ________________________

Home Address: ____ _________

Cell Phone: (______)_____________________________Email:____

<Insurance>

Insurance Carrier: ___________________________ Name of Policy Holder: ____________________________________

Policy Holder's Date of Birth ___________________ Policy Holder's Social Security No. __________________________

Policy Number: ___________________________________ Group Number: _____________________________________

Do you have Orthodontic Coverage: Y N Max ______________ Age limit ___________________ Deductible ____________

***** Initial Consultation & Any images during consultation: Patients do not pay but our office will file claims to patient's insurance.**

The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. Your signature below indicates that You understand accept this policy. You herein authorize payment of dental benefits to the Doctor when an assigned claim is filed.

Signature: ____ Date: ______________________________