PULLMAN FAMILY DENTISTRY, PLLC

JACK CHIANG, DDS MAGD FICOI

PATIENT REGISTRATION

We welcome you as a new patient and appreciate the opportunity to provide you and your family with complete professional dental service. Please help us by completing all the information requested below. Thank you!

PLEASE PRINT CLEARLY

Patient's Name: (Last)______________________________(First)_________________________(MI)_____

Birth Date: ______________________ Social Security/ ID #: ____________________________ Sex: M F

Street or Mailing Address:____ Apt #:__________

City, State, Zip:____

Home Phone: _______________Work Phone: _______________Ext: _____Cell Phone: _____________

Email: ____________________________Contact preference:____________________________ AM or PM?

Employer/ School (if full time student):_______________________Insurance Company:_______________

Marital Status: Single Married Divorced Separated Widowed

Emergency Contact:____________________ Relationship to Patient: ____________Phone:___________

How did you hear about Pullman Family Dentistry or Dr. Chiang?_________________________________

IF PATIENT IS UNDER 18 *OR* NOT THE POLICY HOLDER ON INSURANCE,

PLEASE COMPLETE THE FOLLOWING:

Responsible Party/ Policy Holder: (Last)________________________(First)________________(MI)____

Birth Date: ____________________ Social Security/ ID #: _____________________________ Sex: M F

Street or Mailing Address:____ Apt #:__________

City, State, Zip: ____

Home Phone: _______________Work Phone: _______________Ext: _____Cell Phone: _____________

Employer:______________________________ Insurance Company:_________________________________

By signing below, I verify that the above information is correct and agree to pay any balance incurred by services rendered. **Payment is expected on the date of service unless other financial arrangements are made prior to the appointment.** If no payment is received within 90 days of treatment, I understand that submission to a collection agency may become necessary and that a 20% collection fee will be added to my account.

For insurance claims, I authorize the release of any information regarding treatment to my insurance company, and that any payment by my insurance is to be issued directly to Pullman Family Dentistry.

I consent to the taking of x-rays, photographs, and videos before, during, and after treatment and to the use of same by the doctor in scientific papers and demonstrations.

SIGNATURE:____DATE:______________________

(Patient or Legal Guardian)