

PULLMAN FAMILY DENTISTRY, PLLC

JACK T. CHIANG, DDS FAGD

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

Patients Name :(Last) _____ (First) _____ (MI) _____
Street Address: _____ Apt #: _____
City, State, Zip: _____ Sex: M F
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Birth Date: _____ Soc. Sec #: _____ Drivers License #: _____
Employer: _____ If Patient is a full time student, Name of School _____
Email: _____ Would you prefer to be contacted by email? Yes No
Marital Status: Single Married Divorced Separated Widowed
Patient's Spouse: _____ Spouses Employer: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about Pullman Family Dentistry or Dr. Chiang? _____

IF PATIENT IS NOT RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT, PLEASE COMPLETE THE FOLLOWING:

Name of responsible party :(Last) _____ (First) _____ (MI) _____
Street Address: _____ Apt #: _____
City, State, Zip: _____ Sex: M F
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Birth Date: _____ Soc. Sec #: _____ Drivers License #: _____
Employer: _____

I verify that the above information is correct and agree to pay 1.5% per month (Annual Rate 18%) on any of my charges that are not paid within 30 days from the date of treatment. If submission to a collection agency becomes necessary I understand that a 20% collection fee will be added to my account. Unless other financial arrangements are made, payment is expected when treatment is rendered even in cases that take more than one visit to complete the treatment. A charge will be made for no shows, cancellations or reschedules without 24 hours notice and for duplicating of x-ray.

For insurance claims: I authorize the release of any information relating to this claim and the use of a photocopy of the treatment plan for services rendered. I authorize payment directly to Pullman Family Dentistry, PLLC of the insurance benefits otherwise payable to me. **I also agree to be responsible for any balance occurring on this account**, including any amount not covered by insurance within two months (insurance pre-determinations are estimates only)

DATE: _____ SIGNATURE: _____
(In case of minor, signature of Parent or Guardian)