L-H (Sam) Chang, D.M.D., P.A. **Family & Esthetic Dentistry**

Patient Information

Patient Name: _____ Date: _____
Last First MI

❍ Male ❍ Female ❍ Married ❍ Single ❍ Child ❍ Other _____

Birth Date (mm/dd/yyyy):_____Driver's Licence #_____

Phone - Home: _____ Work: _____ Ext.: _____Cell:_____

Address: _____
Street Apartment No.

_____
City State ZIP Code

E-mail Address (optional): _____

Employer Name: _____ Occupation: _____

Address: _____
Street City State ZIP Code

Emergency Contact Information

Name: _____ Date: _____
Last First MI

Phone - Home: _____ Cell: _____ Work: _____Ext.:_____

Dental Insurance Information

Primary
Subscriber Name: _____ Is subscriber a patient? ❍Y ❍N
Last First MI

Subscriber's Birth Date (mm/dd/yyyy): _____ ID#: _____ Group#: _____

Subscriber's Address: _____
Street City State ZIP Code

Subscriber's Employer Name: _____

Address: _____
Street City State ZIP Code

Patient's relationship to subscriber: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Dental Insurance Plan: _____

Insurance Address: _____

Insurance Phone Number: _____

Referral Information

Whom may we thank for referring you to our practice? ❍ Another patient ❍Yellow Pages ❍Other_____

Name of person or office referring you to our practice: _____

Please turn page for important financial information