WELCOME

562-426-6594 **Lowry Y Wong, DDS** lywongdds@gmail.com

1. Personal Information

Date _____

Name _____

Address _____

City, State, zip _____

Age: _____ Date of Birth: _____ Driver's License No. _____

SSN: _____ Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married

How did you hear about our office? _____

Employed By: _____ Occupation: _____

Work Address and City: _____

Home Phone No. _____ Work Phone No. _____

Cell Phone No. _____ E-Mail _____

Preferred Contact Method for Appointment _____

In Case of Emergency Who Should We Contact? Name _____

Relationship: _____ Phone No. _____

2. Responsible Party

Person Responsible for This Account: _____

Name and Relationship to Patient _____

Date of Birth _____ Social Security Number _____

Insurance Company _____

Secondary or Additional Insurance _____

Subscriber ID No. _____

Please Complete Other Side

3. Consent for Treatment, Insurance Payment Authorization and Financial Policy Disclosure

I authorize the dentist to release any information including the diagnosis and the record of any examination or treatment rendered to me or my child during the period of such dental care to third party payers and/or other health care providers.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third party or insurer to my provider. If I have insurance, I agree to make a payment of my estimated co-payment at the time of services rendered. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules. After 60 days from the time of treatment, any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collection from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third party payer fail, refuse or otherwise neglect to make payment. All collections from third parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for service rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a $25 fee for appointments missed or cancelled with less than 24 hour advanced notice. This office reserves the right to charge interest of APR = 12% for overdue balances. Inconsideration for the professional services rendered to me by this dental office, I agree to pay the reasonable value of said services to the Doctor or his assignee at the time services are rendered or within 15 days of billing if credit is extended. I further agree that a waiver of any breach of any time or condition, hereunder shall not constitute a waiver of any further term or condition and I agree to pay all costs of collection, including attorney's fees and expenses incurred to collect any unpaid bills.

Signature _____ **Date** _____

Signature of Patient or Parent if Minor