



David Lee, DDS, FAGD

Welcome to our practice. Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ Male Female

Address (Street, City, State, ZIP) _____

Date of birth _____ Age _____ Social security no. _____

Home phone () - _____ Work phone () - _____ Cell phone () - _____

Primary contact number (please check one) Home Work Cell Fax () - _____

E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's date of birth _____

Spouse's social security no. _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone _____

Grade _____ Social security no. _____

Payment is due in full at the time of treatment (Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____