



ELLIS WONG DDS INC.

Today's Date: \_\_\_\_\_

**Patient Registration Information**

**Personal Information**

Full Name: \_\_\_\_\_  
Last First M.I. I prefer to be called

Birth Date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Patient is:  Single  Married  Domestic Partner  Divorced  Separated  Widowed  Minor  
 Social Security Number: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_ City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Spouse/Partner Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_

**Employer Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ How Long? \_\_\_\_\_

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Insured Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured SS/ID# \_\_\_\_\_  
 Employer: \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Secondary Insurance Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Insured Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured SS/ID# \_\_\_\_\_  
 Employer: \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Billing Information**

Person ultimately responsible for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Method of Payment:  Cash  Check  Credit Card

**Terms and Conditions**

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. **I fully understand I am solely responsible for any balance not paid by my insurance company and that Dr. Wong is not a preferred provider.** I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.

I give my consent for the doctor and staff to use any photos he may take to be used for education or lecturing purposes.

I understand the office policy requires payment in full for services rendered at the time of visit unless other arranges have been made in advance. I am responsible to pay for any services over 90 days old and for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of payment of my account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_