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:*** ____________

607 North Larchmont Boulevard | Los Angeles, California 90004
Phone (323) 464-5555 | Fax (323) 464-3075

[01/2012]