Welcome to Dr. Tim Choy's office! Please complete the following confidential form.

Getting to know You as our Patient

A. ***PATIENT INFORMATION*** APPOINTMENT DATE

FULL NAME I PREFER THE NAME

BIRTH DATE SOCIAL SECURITY #

ADDRESS CITY/STATE/ZIP

PHONE EMAIL CONTACT BY ☐ PHONE ☐ EMAIL

EMPLOYER/SCHOOL EMPLOYER/SCHOOL PHONE

STATUS ☐ CHILD ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSE/PARENT NAME SPOUSE/PARENT PHONE

EMERGENCY CONTACT RELATION PHONE

DO WE CARE FOR OTHER MEMBERS OF YOUR FAMILY OR CLOSE FRIENDS?

B. ***FINANCIAL INFORMATION*** STATEMENTS BY ☐ MAIL ☐ EMAIL

PERSON RESPONSIBLE FOR ACCOUNT ☐ SELF: PLEASE SKIP TO SECTION C ☐ OTHER: NAME

RELATION TO PATIENT PHONE

BILLING ADDRESS

C. ***DENTAL INSURANCE INFORMATION*** ☐ I AM THE POLICY HOLDER AND WILL PROVIDE MY DENTAL INSURANCE CARD: PLEASE SKIP TO SECTION D

PRIMARY INSURANCE COMPANY GROUP # ID #

POLICY HOLDER NAME RELATION TO PATIENT

POLICY HOLDER BIRTH DATE POLICY HOLDER SS#

POLICY HOLDER EMPLOYER

SECONDARY INSURANCE COMPANY GROUP # ID #

POLICY HOLDER NAME RELATION TO PATIENT

POLICY HOLDER BIRTH DATE POLICY HOLDER SS#

POLICY HOLDER EMPLOYER

D. HOW DID YOU HEAR ABOUT OUR OFFICE?

- ☐ SIGN ON BUILDING
- ☐ INTERNET SEARCH
- ☐ YELP
- ☐ REFERRED BY A FRIEND OR FAMILY MEMBER: _____
- ☐ INSURANCE PROVIDER
- ☐ REFERRED BY A SPECIALIST: _____

E. TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies as a courtesy and will credit such collections to my account. However, the dental office cannot render services on the assumption that charges will be paid by an insurance company.

I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me to discuss matters related to this form.

I read the above conditions and agree to their content. All information provided is accurate to the best of my knowledge.

SIGNATURE _____ **DATE**_____