Welcome_____

Ken Yasuhara, DDS

Welcome to our practice! We appreciate your trust and look forward to working with you in providing optimal dental care. Please fill out the following forms as completely as possible.

Patient's Name_____ Today's Date_____
□ Male □ Female Single □ Married □ Child □
Date of Birth_____ Social Security #_____
Mailing Address _____
_____
E-mail Address _____
Home Phone # _____Work Phone #_____
Cellular Phone # _____Other Phone # _____
Place of Employment _____
Present Position_____ How long Held_____
Emergency Contact Person _____ Relationship to Patient_____
Phone # _____

Whom May We Thank for Referring you to our office _____

Person Responsible for Account **if patient is a Minor** _____
Date of Birth_____ Social Security #_____
Address if different from Patient _____
_____

Primary Dental Insurance Coverage:
Employee Name_____
Date of Birth_____
Social Security # _____
Name of Ins. Co._____
Group #_____

Secondary Dental Insurance Coverage:
Employee Name_____
Date of Birth_____
Social Security #_____
Name of Ins. Co._____
Group #_____

Please Provide a copy of your insurance card for our records.

Consent:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize the release of any information concerning my (or my child's) health care, advice the treatment to another dentist.
I authorize the payment of insurance benefits directly to the dentist group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for service. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous statements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____ _____
Patient or Guardian's Signature Date

PATIENT REGISTRATION