WELCOME

UEHARA FAMILY COSMETIC DENTISTRY

Garret Uehara DDS Jill Uehara DMD

Welcome to our dental family! Please complete the following forms as completely as possible.

Patient's Name _____ Today's Date _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child

Date of Birth _____

Mailing Address _____

Employer: _____ Position: _____

E-mail Address _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Other Phone # _____

Emergency Contact Person _____ Relationship to Patient _____

Phone # _____

How did you hear about our office? ☐ Yelp ☐ Yellow Pages ☐ Internet Search ☐ Other

☐ Referral If by referral, whom can we thank? _____

Person Responsible for Account **if patient is a Minor** _____

Date of Birth _____

Address if different from patient _____

_____

PRIMARY Dental Insurance Coverage:

Subscriber Name _____

Date of Birth _____

Ins Carrier (HDS,…)_____

Subscriber # _____

SECONDARY Dental Insurance Coverage:

Subscriber name _____

Date of Birth _____

Ins Carrier Name _____

Subscriber # _____

Please Provide a copy of your insurance card and a picture ID 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 and/or 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 insurance carrier or payor of my dental benefits may pay less than the actual bill of 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