PATIENT REGISTRATION FORM

DATE : _____

Y. Emily Yu, D.M.D., M.S.D.
Practice Limited To Orthodontics

PERSONAL

PATIENT FULL NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO.(IF ADULT)		AGE	BIRTHDATE
STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE / CELL PHONE ( )
STREET ADDRESS WHERE PATIENT LIVES (I F DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE	HOME PHONE / CELL PHONE ( )
DENTIST NAME			REFERRED BY	

PARENT EMPLOYMENT (CHILD PATIENT)

FATHER'S NAME				MOTHER'S NAME			
FATHER'S STREET ADDRESS				MOTHER'S STREET ADDRESS			
CITY	STATE	ZIP CODE	HOME PHONE ( )	CITY	STATE	ZIP CODE	HOME PHONE ( )
EMPLOYED BY		HOW LONG?		EMPLOYED BY			HOW LONG?
BUSINESS PHONE NUMBER ( )				BUSINESS PHONE NUMBER ( )			
OCCUPATION				OCCUPATION			
FATHER'S SOCIAL SECURITY NO.				MOTHER'S SOCIAL SECURITY NO.			

BILLING/ RESPONSIBLE PARTY

NAME OF PERSON WHO PAYS BILL			SOCIAL SECURITY NO.	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE ( )

EMPLOYMENT OF ADULT PATIENT

EMPLOYED BY	HOW LONG?		POSITION	
BUSINESS ADDRESS	CITY	STATE	ZIP CODE	PHONE ( )

ORTHODONTIC INSURANCE INFORMATION

INSURANCE COMPANY NAME		
NAME OF SUBSCRIBER #1		SOCIAL SECURITY # OF SUBSCRIBER #1
BIRTHDATE OF SUBSCRIBER #1	GROUP NUMBER	EMPLOYER'S NAME & PHONE NUMBER ( )

IF DUAL ORTHODONTIC COVERAGE

INSURANCE COMPANY NAME		
NAME OF SUBSCRIBER #2		SOCIAL SECURITY # OF SUBSCRIBER #2
BIRTHDATE OF SUBSCRIBER #2	GROUP NUMBER	EMPLOYER'S NAME & PHONE NUMBER ( )

Everything I have stated in the application is true to the best of my knowledge, and is an accurate statement of my obligations. You are authorized to check my employment history, and release this information to my insurance company, if so requested.

FULL SIGNATURE OF RESPONSIBLE PARTY

X	DATE