CONFIDENTIAL PATIENT REGISTRATION FORM

NAME:_____DATE:_____

PREFERS TO BE CALLED: _____

ADDRESS: _____ CITY: _____STATE:_____ZIP:_____

PHONE: (HOME)_____ (WORK) _____ (MOBILE) _____

E MAIL: _____HOW WOULD YOU PREFER TO BE CONTACTED?_____

D.O.B.:_____SEX: M F MARITAL STATUS: M S D W SPOUSES NAME _____

SS#_____STUDENT: Y N WHERE: _____

OCCUPATION: _____EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____EMPLOYER PHONE:_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE COMPANY NAME: _____GROUP #_____

POLICY HOLDER'S NAME: _____D.O.B._____SS#_____

POLICY HOLDER'S EMPLOYER AND ADDRESS: _____

_____

POLICY HOLDER'S RELATIONSHIP TO PATIENT: _____

SECONDARY INS. CO. NAME: _____GROUP #_____

POLICY HOLDER'S NAME: _____D.O.B._____SS#_____

POLICY HOLDER'S EMPLOYER AND ADDRESS: _____

_____

POLICY HOLDER'S RELATIONSHIP TO PATIENT: _____

CONSENT FOR TREATMENT

To the best of my knowledge, all the preceding and forthcoming answers are true and correct. If I have any change in my health or medications, I will inform Dr. Zhang and his staff at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I authorize Dr. Zhang or designated staff to take x-rays, study models, photographs or other diagnostic measures appropriate for a thorough evaluation and diagnosis. Upon such diagnosis, I authorize Dr. Zhang and designated staff to perform any treatment mutually agreed upon by me and to employ such assistance as required for proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that the use of anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I agree to assume all financial responsibility of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient signature: _____Date:_____