PRINT

Duke N. Bui, DDS, PS

PATIENT INFORMATION

Patient Name _____ Preferred Calling Name _____

Social Security # _____ DOB: _____ ☐Male ☐Female

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail Address _____

Employer _____ Occupation _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Domestic Partner

How did you hear about our office? _____

Whom may we thank for referring you to our office? _____

Do you prefer to be contacted for appointment confirmation via (check all that apply): ☐E-mail ☐Phone ☐Text Message

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber Name: _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

SECONDARY INSURANCE

Subscriber Name: _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

EMERGENCY INFORMATION

Name of nearest relative NOT living with you _____ Relationship _____

Address _____ Phone _____

PLEASE READ AND SIGN

I hereby certify that the above information is true and correct. I acknowledge that I am financially responsible for all charges whether or not paid by Insurance. If it becomes necessary to effect collections of balance due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Signature _____ Date _____