Personal Information

Please Print

Today's Date: ______________________

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

First Name: ______________________ Initial: ___ Last Name: ___________________________
Prefer to be called: ___________________

Date of Birth: Day ____ Month ____ Year _______ Age: _____
Address: ____

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Phone Numbers:
Home #: ____________________ Work #: ____________________ Cell #: __________________
Email Address: _____________________________________

Marital Status: _______________________
Name of Spouse (adults) or Parents (children): ____
Spouse Work #: ____________________ Cell #: __________________
Mom Work #: ____________________ Cell #: __________________
Dad Work #: ____________________ Cell #: __________________

Are you a student? Yes ☐ No ☐ School: ___________________________________
Occupation: __________________________ Employer: _________________________________

How did you hear about our office? ____
Are other family members patients at our office?
Names:____

Are you covered by Dental Insurance? Yes ☐ No ☐
Name of Insurance Company ____
Group/Policy #: __________________ I.D. or Certification #: ___________________________
Name of Policy Holder: __________________________ Date of Birth: Day ___ Mth ___Yr_____

In case of emergency please notify: ____
Relationship: _____________________
Home #: ____________________ Work #: ____________________ Cell #: __________________

Office Policies

We would like to take this opportunity to thank you for your trust and confidence in our office. We appreciate having you as a patient and we will do everything in our power to ensure that you receive the best possible dental care.

We respect and value your time and appointments booked by you are especially reserved for you. We also ask that you respect our time and commitment to provide excellent service to ALL of our patients. Therefore, we have implemented the following office policies:

- The length of your appointment is based on your individual treatment. Please respect the time we have reserved for you.
  - Your appointment will need to be rescheduled if the appropriate time to provide quality dental services is no longer available.

- Should a change of appointment be necessary, we require 48 business hours notice or a $50.00 fee will be applied to your visit.

- Payment is due on the date of service for dental services. If you have any concerns, please consult our front desk staff prior to your appointment.

- Your dental coverage is an agreement between you and your insurance company. We will gladly submit your dental claims electronically on your behalf. If you have any questions concerning your coverage or any past claims, please contact your insurance company directly.

We thank you for your cooperation and look forward to providing exceptional dental care to you and your family.

Sincerely yours,

Dr. Karen Fung DDS
Dr. Chev Harris DDS
& Associates

I have read and understand the above

Signed:___________________________________ Date:_________________

Witness:__________________________________ Date:_________________