Advanced Family Dental

Phu H. Le, D.D.S.

WELCOME. Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. Please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

REGISTRATION AND TREATMENT

PATIENT INFORMATION

Date:_____

Name: _____ Preferred Name:_____
Last First Middle

Address:_____ Soc. Sec.#_____

City:_____ State:_____ Zip:_____ Driver Lic._____

Home Phone:( )_____ Cell Phone:( )_____

Work Phone:( )_____ Ext_____ E-mail:_____

Sex ❑ Male ❑ Female Age_____Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____years

Patient/Employer School_____Occupation_____

Employer/School Address_____

Whom May we thank for referring you?_____

In case of an emergency who should be notified_____Phone( )_____

PRIMARY INSURANCE

Subscriber Name_____
Last First Middle

Relation to Patient_____ Birthdate:_____Soc.Sec.#_____

Address(if different from patient's)_____Phone:( )_____

City_____ State: _____Zip:_____

Subscriber Employed by_____ Occupation_____

Business Address_____ Business Phone( ) Ext.

Insurance Company_____ Insurance Phone Number_____

Group #_____ Subscriber #_____

Name of other dependants covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑Y ❑ N

Subscriber Name:_____ Relation to patient_____Birthdate_____
Last First Middle

Address (if different from patients)_____Phone: ( )_____

City_____ State _____ Zip _____

Subscriber Employed By_____ Business Phone( ) Ext

Insurance Co_____ Soc. Sec.#_____

Insurance Phone ( )_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependants covered under this plan_____