Henry H. Chang, D.D.S., M.S.
Periodontology
12948 Village Dr., Suite A, Saratoga, CA 95070
408.777.0110

PATIENT INFORMATION

Date _____

Patient Name:

_____

Address:

_____

_____
City State Zip

Home (_____) _____

Work (_____) _____

Mobile (_____) _____

Email _____

Gender: ☐ M ☐ F ☐ Others

Date of Birth _____

ID/SS# _____

☐Single ☐Married ☐Widowed
☐Separated ☐Divorced

Occupation:

_____

Employer:

_____

Spouse's Name:

_____

D.O.B. _____ ID/SS# _____

Spouse's Employer:

_____

Who is your referring dentist or person?

_____

Emergency Contact:

Name _____

Phone _____

PRIMARY INSURANCE

Subscriber's Name:

_____

D.O.B. _____ID# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

SECONDARY INSURANCE

Subscriber's Name:

_____

D.O.B. _____ ID# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE IFORMATION

I, the undersigned, certify that I (or my dependent) have aforementioned insurance coverage and assign directly to Dr. Henry H. Chang all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Notice of Privacy Practices

I hereby acknowledge that I have read this dental practice's Notice of Privacy Practices.

Signed _____
Patient (Parent or Guardian)

Date _____

(continue)