Chris Choe Dentistry, PLLC
Welcome Form

Patient Information (CONFIDENTIAL)

Name:_____Birthday:_____ SS#/SIN: _____

Address: _____

City:_____ Zip Code: _____E-Mail: _____

Home Phone:_____ Work Phone: _____Cell Phone: _____

Person to Contact in Case Of Emergency:_____ Phone: _____

When was the last visit to the dentist?: _____

Whom May We Thank for Referring You?:_____

Please circle: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College: _____ City: _____

State: _____ Are you Over 18?:_____ if NO, Responsible info needed below

Responsible Party (if the patient is under 18 years old)

Name Of Responsible Party: _____ Relationship to Patient: _____

Address: _____ City: _____ ZipCode:_____

Home Phone:_____ Work Phone: _____Cell Phone: _____

Birthday: _____ SS#/SIN: _____ Driver License #: _____

Is This Person Currently a Patient in Our Office? ___ Financial Institution: _____

Full Payment Required for Service Rendered.

Insurance Information (only for the patients with insurance)

Name of the Insured: _____ Relationship to Patient:_____

Birthday: _____ SS#/SIN: _____ Date Employed: _____

Name Of Employer: _____ Union or Local#: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____

Insurance Company: _____ Group #: _____ Policy ID:_____

Ins Co. Address: _____ City: _____ State: _____

How Much is your Deductible?: _____ Max. Annual Benefit: _____

When was your last visit to the dentist?: _____

Do you have any additional Insurance? Please let us know.