Dai-Chen Liu, D.D.S. and Fei-Ya Hu, D.D.S., M.S.

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Work phone no.: ( )				
Cell phone no.: ( )	e-mail address:					
If college student: F.T. / P.T.	Name of school:	City:	State:			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )	
Is this person a patient here? ❑ Yes ❑ No				
Is this patient covered by insurance? ❑ Yes ❑ No				
Name of your primary insurance				
Employer:	Employer address:	Employer phone no.: ( )		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Do you have additional insurance?	❑ Yes	❑ No	If yes, please complete the following:	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*