Peter Fay DMD Erik Wong DMD

• prosthodontists •

Name: _____ Birthdate: _____ ☐ Male ☐ Female
Last First Middle Initial

Address: _____
(mailing) Street City State Zip Code ☐ Single ☐ Married

Address: _____
(residence) Street City State Zip Code

Telephone (home): _____ (cell): _____ Social Security # _____

Telephone (work): _____ ext: _____ Employer: _____

E-Mail Address: _____

Name of Spouse: _____ Social Security # _____

Birthdate: _____ Employer: _____

Person Responsible for This Account: _____

In Case of Emergency Who Should We Notify? _____ Telephone: _____

Do You Have Dental Insurance? ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

Is There Secondary Dental Insurance ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

Health History:

Name of Your Physician: _____ Date of Last Physical: _____

Are You Taking Any Medications? ☐ Yes ☐ No If Yes, What? _____

Do You Have Any Allergies (or Adverse Reactions) To Any Medications, Latex Materials Etc… ☐ Yes ☐ No

If Yes, What? _____

Please Circle Any of The Following That Apply:

Heart Problem	AIDS	Tuberculosis	Artificial Joints	Psychological or
Rheumatic Fever	HIV Antibodies	Emphysema	Abnormal Bleeding	Psychiatric Treatment
Hi Blood Pressure	Cancer	Asthma	Ulcers	Other: _____
Lo Blood Pressure	Hepatitis	Diabetes	Fainting	
Pacemaker	Tobacco Use	Epilepsy	Pregnant	**None Apply**

How were you referred to our office? _____

I grant authority to Erik K Wong, D.M.D. and his practice auxiliaries to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable.. Patient and/or legal guardian/parent will be informed before treatment is performed.

I authorize the practice of Erik K Wong, D.M.D. to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.

I consent to the taking of photographs and videos before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I hereby certify the above to be true and correct to the best of my knowledge.

Authorized Signature: _____ Date: _____

Your signature is a file signature for insurance and credit card purchases

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