pediatric dental at Bridgeport

Ben Kang DMD, MS, PC
Board Certified Pediatric Dentist

Patient's Name

_____ Birth Date___/___/___ Sex M F
Last Name First Name Middle Nick Name

Address_____Apt#_____

City_____State_____Zip_____Home Phone_____Cell Phone_____

Emergency Contact: (Please list contact other than parent/guardian)

_____ _____ _____ _____
Name Relationship to patient Home Phone Work Phone

Parent or Guardian Informaiton

Parent 1 _____ ___/___/___ _____
Last Name First Middle Birth Date Drive License #

Address Same as Patient _____Apt#_____

City_____State_____Zip_____Home Phone_____Cell Phone_____

Employer_____Occupation_____ Work Phone_____

E-mail Address_____

Parent 2 _____ ___/___/___ _____
Last Name First Middle Birth Date Drive License #

Address Same as Patient _____Apt#_____

City_____State_____Zip_____Home Phone_____Cell Phone_____

Employer_____Occupation_____ Work Phone_____

E-mail Address_____

Patient's Insurance Information

Primary Insurance

_____ _____ _____
Insurance Company Claim Address Insurance Phone Number

Subscriber_____ ___/___/___ _____
(Legal Name) Date of Birth Relationship to Patient

ID#_____ Group#_____ Effective Date___/___/___

Secondary Insurance

_____ _____ _____
Insurance Company Claim Address Insurance Phone Number

Subscriber_____ ___/___/___ _____
(Legal Name) Date of Birth Relationship to Patient

ID#_____ Group#_____ Effective Date___/___/___

Referred by:_____

I hereby authorize Pediatric Dental at Bridgeport to provide dental services to the above named patient and to use and release medical and dental information as required for treatment, payment, and health care operations. I also assign Pediatric Dental all payments to which I am entitled for dental procedures. I understand that I am financially responsible for all changes weather covered by insurance or not. I have received a copy of the current Privacy Notice and financial policy.

Please check if you **DO NOT** want to be contacted by:
Post card via US mail ☐ Phone call ☐ E-mail ☐ Text message to cell phone ☐

Parent/Guardian Signature_____Relationship to patient_____ Date___/___/___