Dr. Dennis Chen
10430 S. De Anza Blvd. #185
Cupertino, CA 95014

1117 S. Park Victoria Dr.
Milpitas, CA 95035

# PATIENT REGISTRATION

Name: ___________________________, ________________________________________ MR/MRS/MISS/MS/DR
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Birthday: ______/______/_________ ID/SSN: _______________________ Driver License#: _________________

Address: ____________________________________________________________________________________
(STREET)

City: __________________________, CA ZIP _______________ Email____________________________________

Home Phone # (____) ______________ Work # (_____)____________Cellular: (_______) __________________

If full time student, School Name: __________________________________________ Grade: ________________

**NOTIFY IN CASE OF EMERGENCY** (Other than Immediate Family Household)

Name: ______________________________________ Phone #: _________________________________________

**REFERRED BY**: ☐ Doctor ☐ Friend ☐ Newspaper ☐ Other

Name: ______________________ Phone #: _____________ Address: _____________________________________

**PRIMARY INSURANCE INFORMATION**

Insurance Co: ________________________________

Group number: _______________________________

Address: ____________________________________

Phone: (_______)_____________________________

Insured Name:________________________________

Birthday: _________/__________/ ______________

ID/SSN:_____________________________________

Relationship to Patient:_______________________

Employer Name: ______________________________

Occupation: __________________________________

Address: ____________________________________

City: ____________________, CA ZIP ___________

Work Phone #: (_______)_____________Ext_____

**SECONDARY INSURANCE INFORMATION**

Insurance Co: ________________________________

Group number: _______________________________

Address: ____________________________________

Phone: (_______)_____________________________

Insured Name:________________________________

Birthday: _________/__________/ _____________

ID/SSN: _____________________________________

Relationship to Patient: _______________________

Employer Name: ______________________________

Occupation: __________________________________

Address: ____________________________________

City: ____________________, CA ZIP __________

Work Phone #: (_______)_____________Ext______

**AGREEMENT:**

I hereby authorize the release to Dr. Dennis Chen of any information needed concerning my medical and/or dental condition or treatment. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless Dr. Chen has a contractual agreement with my plan prohibiting all or a portion of such charge. I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Chen.

Signed: ______________________________________________________________ Date: __________________