Suk young Ahn DDS
DENTISTRY FOR CHILDREN & TEENS

Patient Information

Date: _____

Patients Name: _____ Nickname: _____

Date of Birth: _____ Referred by: _____ ☐ Male ☐ Female

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Date of Birth:_____

Social Security Number: _____ DL #: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____ Employer: _____

Address: _____

Apt #. City Zip

☐ Father ☐ Step Father ☐ Guardian

Name: _____ Date of Birth:_____

Social Security Number: _____ DL #: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____ Employer: _____

Address: _____

Apt #. City Zip

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous/Present Dentist: _____ Date of last visit: _____

Primary Dental Insurance

Insurance Co. Name: _____

Phone Number: _____

Group Number/ Plan: _____

Employer: _____

Policy Holder's Name: _____

Date of Birth: _____ID#:_____

Secondary Dental Insurance

Insurance Co. Name: _____

Phone Number: _____

Group Number/ Plan: _____

Employer: _____

Policy Holder's Name: _____

Date of Birth: _____ ID#: _____

I certify that my child is covered by _____ Insurance Company and assign directly to Dr. Suk Young Ahn all insurance benefits otherwise payable to me. I understand that I am responsible to inform the office of any changes in my child's insurance or medical statuses. I authorize the dental staff at Dr. Suk Young Ahn's office to perform any necessary dental services my child may need.

Signature: _____ Date: _____

Relationship to Patient: _____