SUMMIT COSMETIC DENTISTRY
SYDNEY CHAU, D.D.S., P.C.
425 S. Summit Ave.
Fort Worth, TX 76104

PATIENT INFORMATION

Date:______________________________

Patient Name (Mr. Ms. Miss. Jr. Sr.):____
First Middle Initial Last

Social Security#:____ Birthday:_________________________________

Circle Applicable: Adult/Child Male/Female Single/Married Divorced/Widowed

If Minor, Parent or Guardian's Name: _________________________

Street Address:____ _____ Home Phone:____________________________

City/State/Zip:____ _____ Cell Phone:______________________________

Spouse/Parent's Name:___________________________________ _____ Their SS#:______________________________

Address (If different):__________________________________ _____ Their Birthday:___________________________

Whom may we thank for referring you?____

DENTAL INSURANCE INFORMATION

Appointment Date: __________________________ Insurance Name: ___________________________

Subscriber's Name: _____________________ ____ Subscriber's SS/ID # ___________________________

Group Number: _____________________ ____ Ins. Phone #: ___________________________

Subscriber's DOB: _____________________ ____ Relationship to Patient: ___________________________

Subscriber's Employer: __________________________ Employer's Number: ___________________________

Patient's Name: __________________________ Patient's DOB: _____________________ _____

Patient's Phone #: __________________________

I hereby instruct and direct _________________________________Insurance Company to pay directly to Sydney Chau, D.D.S., P.C.,
(your insurance company's name)
at the above address. If my current policy prohibits direct payment to Sydney Chau, D.D.S., P.C., I hereby also instruct and direct you to make out the check to me and mail it to the above address as well for the professional dental benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Sydney Chau, D.D.S., P.C., and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that I am financially responsible for all charges whether or not my insurance pays. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Patient, Parent, or Guardian: __________________________ Date: ___________________________________

Please Print: ____