

Patient Registration

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Welcome to our office. We appreciate the confidence you place with us to provide dental services. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____
Last Name First (Legal) Name M.I.
Nickname (the name you would like us to call you) _____
Address _____
City _____ State _____ Zip _____
Phone (H) _____ (W) _____
(C) _____ E-mail _____ (optional)
Social Security # _____
Birthdate _____ (mm/dd/yyyy) Age _____
Sex: M / F Marital Status: Single / Married
Are you a full-time student? Yes / No
If Yes, which school? _____
Would you like to be contacted by our email promotions?
Yes / No

Responsible Party (if same as above, please skip)

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell / Work _____
Social Security # _____
Relationship to Patient _____
Birthdate _____ Age _____ Sex: M / F

Person to Contact for Emergency

Name _____ Relationship _____
Phone / Cell _____ Ext _____

Insurance Information

Primary Insurance Company

Subscriber's Name _____
First Last M.I.
I. D. # _____ Birthdate _____
Subscriber's Employer _____
Insurance Company _____
Ins. Co. Address _____
Ins. Co. Phone # _____
Plan Name _____ Group # _____

Secondary Insurance Company (if patient is covered)

Subscriber's Name _____
First Last M.I.
I. D. # _____ Birthdate _____
Subscriber's Employer _____
Insurance Company _____
Ins. Co. Address _____
Ins. Co. Phone # _____
Plan Name _____ Group # _____

Getting to Know You

How did you hear of us? _____
Whom may we thank for referring you? (if applied)

* We will send special gift to patient who refers you

I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies. I hereby authorize payment directly to Dr. Hsu insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any info. relating to any dental claim or claims.

signature of responsible party or patient Date