Phone: 585-865-4674 www.RochesterDental.com Fax: 585-621-8630
CHEN FAMILY DENTISTRY OF ROCHESTER, PLLC
2070 LYELL AVENUE, SUITE 200, ROCHESTER, NY 14606

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms	❑ Dr. ❑	Marital status (circle one) Single / Mar / Div / Sep / Wid
Wish to be called:	Occupation:	Date of birth: / /		Age:		Sex: ❑ M ❑ F
Street address:		City:		State:		ZIP Code:
E-mail:		Home phone: Cell phone: Work phone:				
Preferred method of contact? ❑ Home phone ❑ Cell phone ❑ Work phone ❑ E-mail		Best time to call? ❑AM ❑PM ❑ Mon ❑ Tue ❑ Wed ❑ Thurs ❑ Fri ❑ Sat				Referred by(who we thank for):

RESPONSIBLE PARTY INFORMATION

Name:	Date of Birth: / /	Social Security no.: Driver's license no.:		Relationship to patient:
Street address:		City:	State:	ZIP Code:
Employer Name:	Place of employment:		Occupation:	

DENTAL INSURANCE INFORMATION

Primary Insurance

Employer's Name:	Insurance Co. Name:	Policy no.:	Policy Group no.:
Subscriber's Name:	Subscriber's Relationship to Patient:		
Subscriber's Social Security no.:	Subscriber's Date of Birth: / /		

Secondary Insurance

Employer's Name:	Insurance Co. Name:	Policy no.:	Policy Group no.:
Subscriber's Name:	Subscriber's Relationship to Patient:		
Subscriber's Social Security no.:	Subscriber's Date of Birth: / /		

MEDICAL INFORMATION

Primary Physician Name:	Phone no.:		
Previous Dentist Name:	Last dental Visit: / /	Last X-ray taken / /	(bring them with you) (or forward them to us)
Medical issues we should be aware of:			
Do you have allergies? ❑ Yes ❑ No If yes, specify:			
Premed before dental visits? ❑ Yes ❑ No	Any current dental concerns?		

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to my dentist. I understand that I am financially responsible for any balance. I also authorize Chen Family dentistry of rochester, pllc or insurance company to release any information required to process my claims.

Patient/Parent/Guardian's Signature *Date*