Alice Lau, D.M.D, F.A.G.D.
9017 Shady Grove Court
Gaithersburg, MD 20877
Tel: 301-921-8899

PATIENT REGISTRATION_______________________________________

Patient's name____Birthdate__________________
Soc. Sec.# _________________ Phone: Home _______________ Mobile____________________
Work________________ email: _________________
Single ____ Married _____ Widow_______ Divorced______ Seperated______
Address: ____
City_____________________State________________Zip________________
If Student, Name of School/College________________________City_________State_____Zip____
Patient or Parent employed by _________________________Present Position: _______________
Business Address___________________________________City_________State______Zip____
Spouse or Parent's Name __________________________________ Birthrate ________________
Soc. Sec.#_____________________Phone: Work_______________ Mobile________________
Spouse or Parent employed by_______________________________ Position________________
Business Address____________________________________City________State______Zip____
Person to contact in Case of Emergency_________________________ Phone: _______________
Relations: _________________
Person responsible for this account ____

Insurance Information:
Name of insured___________________________________Relationship to Patient_________
Insurance I.D. No: ___________________Soc Sec.# _____________ Birthdate: ___________
Insurance Company_________________________Group #________
Name of Employer__________________Address: ____________________________________

Secondary Insurance:
Name of Insured____________________________________Relationship to Patient________
Insurance I.D. No: ___________________Soc Sec.#____________Birthdate: _____________
Insurance Company__________________________Group #________
Name of Employer___________________Address____________________________________

Purpose of this appointment____
Whom may we thanks for referring you____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. If my account becomes assigned to a legal or collection agency, I agree to pay collection agency fees, court costs and attorney fees. I understand that all unpaid balances over 30 days will be assessed a 1.5 % monthly interest.

I have read and agreed with Dr Lau's office policy. I understand payment is due in full at time of treatment unless prior arrangements have been approved. And appointments cancelled or broken without 48 hours advance notice will be subjected to charge.

____ ________________________________
Signature of patient or parent if minor Date

Review Date: ____________________________________ Initial: ______________