☐ **San Bruno Office**
931 W. San Bruno Ave, Suite 3
San Bruno, CA 94066
Tel: (650) 835-7183
Fax: (650) 588-5889

Wayne W. Lee, D.D.S., Inc.

Cosmetic, Implant, & Family Dentistry

www.wayneleedds.com **e-mail:** drlee@wayneleedds.com

☐ **San Francisco Office**
6100 Geary Blvd, Suite 200
San Francisco, CA 94121
Tel: (415) 386-0790
Fax: (415) 386-0792

This information is necessary for our files and will be considered confidential

Patient's Information: (Please Print)

Patient's Name: _____
Last First **Middle Name**

Home Address: _____
Street Apt# City State Zip Code

Home Phone: _____Cellular Phone _____

Email _____Marital Status: Single Married Widowed Separated Divorced

Date of Birth_____ ☐ Female ☐ Male Do you have dental insurance: ☐ Single ☐ Dual ☐ No

Whom may we thank for referring you to our office? _____

Emergency Contact Person: _____ Phone (_____) _____

Relationship, please circle: Parent Spouse Partner Parents Guardian Conservator, Other_____

Other Individual you authorized to discuss and or receive your Medical Information:

Name: _____

Relationship, please circle: Parent Spouse Partner Parents Guardian Conservator, Other_____

I acknowledge I have received from Wayne W. Lee, D.D.S., Inc. a copy of this office's Notice of Privacy Practices Dated 07/24/2014, and a copy of the Dental Materials Fact Sheet dated May 2004.

Signature: _____Date:_____

Sign here if you **refuse to receive** Notice of Privacy Practices Dated 07/24/2014

Signature: _____Date:_____

For Minor Patient only:

Parent/Legal Guardian Name _____ Contact Phone: (_____) _____

Release:

I authorize Wayne W. Lee, D.D.S., Inc. and the dentists to take necessary pictures for treatment, payment, and Health Care Operations.

I authorize Wayne W. Lee, D.D.S., Inc. and the dentists to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentists.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Cancellation Policy: We understand that emergencies can arise but we ask that you notify our office 24 hours prior to your appointment if you need to cancel or reschedule. Any cancellations within 24 hours will incur a $50 fee.

Patient's or Guardian's Signature _____Date_____