MISSION PARK DENTAL

DR. LINDA WONG & DR. BENSON WONG

New Patient Information

First Name:	Last Name:	Date:
Birthdate:	Gender:	Marital Status:
Address:	City:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
Email:		

Emergency Contact:	Phone:
Health Care Card#:	
Physician Information:	Phone:

Referred By:
Friend/Family:_____________________ Phone Book ☐ Website ☐ Other:________________

Employer/School:	Occupation:

Primary Dental Plan Benefits (please complete to the best of your knowledge)

Insurance Company:				
Policy Holder:	Birthdate:			
Policy/Group#:	ID/Certificate#:	Deductible:		
Basic(A)%:_____ Limit:_____	Major(B)%:_____ Limit:_____	Ortho(C)%:_____ Limit:_____		
Recare (mos): 6 9 12	Comps paid on molars: Yes/No __________	Scaling/RP: Units:_____	Benefit Year: Cal/Roll_________	Pan/Comp Exam Freq:________

Secondary Dental Plan Benefits (please complete to the best of your knowledge)

Insurance Company:				
Policy Holder:	Birthdate:			
Policy/Group#:	ID/Certificate#:	Deductible:		
Basic(A)%:_____ Limit:_____	Major(B)%:_____ Limit:_____	Ortho(C)%:_____ Limit:_____		
Recare (mos): 6 9 12	Comps paid on molars: Yes/No __________	Scaling/RP: Units:_____	Benefit Year: Cal/Roll_________	Pan/Comp Exam Freq:________

Consent to Release of my photos for academic/promotional purposes: Yes: ☐ No: ☐
NO information pertaining to my name or identity will be revealed.
Signature:______________________