Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

Sein H. Siao D.M.D.
and Associates
Family Dentistry

14 Common Street
Wrentham, MA 02093
(508)384-8136

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M.I. _____ Last Name_____
Nickname _____ Sex: ☐ Male ☐ Female Birth Date _____
Email _____
Street _____ City _____ ST _____ Zip _____
Home Tel.(_____)_____Cell(_____)_____ ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single

Employer_____ Bus. Tel(_____)_____
Spouse_____ Work #_____ Cell#_____
Person to call in case of emergency_____ Tel.(_____)_____
College Student ☐ F/T ☐P/T Name of School _____ City/ST _____

Whom may we thank for referring you? ☐ Doctor (Name _____) ☐ Friend (Name_____)
☐ Newspaper ☐ Website ☐ Insurance Plan ☐ Other_____

Who will be responsible for your account?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

(If self, skip to next section)
Name_____ Birth Date_____ Age_____ Tel.(____)_____
Employer _____ Bus. Tel._____

INSURANCE INFORMATION

Primary Dental Insurance Company

Name of Insured _____
Relation_____ Sex:☐ M ☐ F
Birthdate_____SS#_____
Employer_____Local/Union_____

Ins. Co._____ID#_____
Group #_____ Group Name_____
Address_____
City/ST_____Tel.(___)_____

Medical Dr._____

Secondary Dental Insurance Company

Name of Insured _____
Relation_____ Sex:☐ M ☐ F
Birthdate_____SS#_____
Employer_____Local/Union_____

Ins. Co._____ID#_____
Group #_____ Group Name_____
Address_____
City/ST_____Tel.(___)_____

Previous Dentist_____

Permission for Dental Examination and Treatment

I do hereby authorize and consent to any x-rays, examination, anesthetic, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Siao and/or staff members they may deem necessary. This authorization will remain in effect until cancelled in writing by me.

Patient/Parent/Guardian Signature: _____ Date: _____