Encino Orthodontics

# Fouy Chau, D.D.S.,M.S.

# Patient Information

**Date** _____

**Patient's Name** _____ Sex _____ Birthdate _____ Age _____
Last First Initial

Patient's Address _____
Street City State Zip

Place of Employment _____ Occupation _____ Work Ph # _____

Patient Phone # _____ Soc. Sec. # _____ CA. Driver's Lic. # _____

**Mother / Wife's Name** _____

Address _____
Street City State Zip

Place of Employment _____ Occupation _____ Work Ph # _____

Phone # _____ Soc. Sec. # _____ CA. Driver's Lic. # _____

**Father / Husband's Name** _____

Address _____
Street City State Zip

Place of Employment _____ Occupation _____ Work Ph # _____

Phone # _____ Soc. Sec. # _____ CA. Driver's Lic. # _____

Names and Ages of Other Children in the Family _____

**Name of Person(s) Responsible for Account** _____

Responsible party e-mail address _____

**INSURANCE INFORMATION**

Name of Insured _____ Date of Birth _____

Primary Dental Insurance _____
Policy # Group #

Address _____
Street City State Zip

Secondary Dental Insurance _____ Date of Birth _____
Policy # Group #

Address _____
Street City State Zip

**IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT**

Name _____ Home Ph # _____

Home Address _____ Work Ph # _____
Street City State Zip

**REFERRAL**

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