Raymond T. Chu, D.M.D.

Prosthetic and Implant Dentistry

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Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____ Wishes to be called _____

Birthday _____-_____-_____ Age _____ Soc. Sec. # _____-_____-_____

First Name _____ Last Name _____

Male Female Single Married Divorced Widowed

Address _____

City _____ State_____ Zip _____

Employer_____ Occupation _____

Referred by Dr._____ Friend: _____

2 Responsible Party Who is responsible for the account?

First Name _____ Last Name _____

Relationship to patient: Spouse, Parent, Grandparent, other _____

Birthday _____-_____-_____ Driver's License # _____

Social Security # _____-_____-_____ Occupation _____

Address _____

City _____ State ____ Zip _____, E-mail _____

Employer _____

Work Phone _____-_____-_____ Ext.# _____ Home Phone _____-_____-_____

3 Telephone

I do not wish to be reminded for my appointment Please call me the day before my appointment

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Ext.# _____

Cell Phone _____-_____-_____ E-mail address_____

FAX _____-_____-_____ Pager or Voicemail _____-_____-_____

Where do you prefer to receive calls? Home Work Car FAX Voicemail

When is the best time to reach you? Time _____AM/PM Days _____

In the event of an emergency, who should we contact?

First Name _____ Last Name _____ Relationship _____

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Ext.# _____

Please fill out both sides. Thank you!