

ALEXANDER C.Y. LIN, D.D.S., P.C.
1515 7th Street, Suite B, Oregon City, Oregon 97045

Primary Dental Insurance Information

Name of Insured: _____ Is insured a patient? ____ Yes ____ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____ Other _____

Insurance Plan Name and Telephone: _____

Secondary Dental Insurance Information

Name of Insured: _____ Is insured a patient? ____ Yes ____ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____ Other _____

Insurance Plan Name and Telephone: _____

MEDICAL Insurance Information

Name of Insured: _____ Is insured a patient? ____ Yes ____ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____ Other _____

Insurance Plan Name and Telephone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in both of my insurance coverage and medical status. The undersigned hereby authorizes Dr. Lin to order radiographs (x-rays), study models, photographs, or other diagnostic aids deemed appropriate by Dr. Lin to make a thorough diagnosis of the patient's dental needs. I the undersigned understand that Dr. Lin may use these x-rays, study models, photographs, or other diagnostic aids in consultation with other health care providers, teaching institutions, educational purposes and professional publications.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____