



Sein H. Siao, D.M.D and Associate

Clerical Information Update

Mr. Mrs. Ms. Dr. Name (First M.I. Last)

Street Address _____

City _____ ST _____ Zip _____

Home Tel.(____) _____ Cell(____) _____ Work(____) _____

Email: _____

[For your convenience, you will receive your appointment reminders via text and/or email. Please provide us with your most current information.]

Emergency Contact Name: _____ Phone: _____

Has there been any change to your insurance information? Yes No

If yes, please fill in the following information and present new insurance card (if available) to the front desk.

Name of the subscriber _____

Employer of the subscriber _____

Name of insurance company _____

Policy/Group Number _____ Subscriber ID Number _____

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: _____