Rebecca R. Gong D.D.S.
9330 Carmel Mountain Rd. Suite A1
858-201-3577

Patient Information

Circle One: Dr/Mr/Mrs/Ms/Miss

First: ________________________Middle: _______________ Last: ____________________Jr/Sr: _______

Street: ____________________________________ City: ___________________ State: ______ Zip: __________

Home Phone: _______________________Work Phone: __________________ Cell Phone: ________________

Email Address: ______________________________________ May we contact you by email? (circle) Yes No

Patient Social Security Number: ________________ Patient Date of Birth: ____________Sex: (circle) M F

Emergency Contact: __________________________________ Phone: ____________________________

Insurance Information

Do you have Dental Insurance? (circle) Yes No

Do you have Secondary Dental Insurance? (circle) Yes No

PRIMARY INSURED		SECONDARY INSURED	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Patient/ Guardian Signature ______________________________ Date: _________________

Patient/ Guardian Signature ____