Jiyoung E. Lee, DMD
Gresham Pediatric Dentistry

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Welcome to Our Practice!

Thank you for selecting our dental healthcare team at Gresham Pediatric Dentistry! We will constantly strive to provide you, and your child with the best possible dental care.

Patient Information

Today's Date_____
Patient's Name(s) _____ Name Preference(s) _____
Address _____City _____ State___ Zip _____
Contact Phone _____
Email _____
Date of Birth(s) _____

Names of guardian(s) or parent (s) _____
Person to contact for emergency _____ Relationship_____ Phone _____
Whom may we thank for referring you to our office? _____

Responsible Party Information (If different than above.)

Name _____ Relationship to Patient _____
Address _____City _____ State ___ Zip _____
Home Phone _____ Date of Birth _____

Dental Insurance Information

Dental Insurance Co. _____ Effective Date _____
Address _____ City _____ State ___ Zip _____
Name of Policy Holder _____Date of Birth _____
Member # (or SSN #) _____ Group # _____

Secondary Insurance Co. _____ Effective Date _____
Address _____ City _____ State ___ Zip _____
Name of Policy Holder _____ Date of Birth _____
Member # (or SSN #) _____ Group # _____

I acknowledge that the above information is accurate. I hereby authorize payment of benefits directly to the provider, and the release of all necessary information to the insurance carrier. I understand that by signing below I am responsible for charges for all consented treatment, and that fees not covered by insurance are due on the day of service.

Signature _____ Date _____