Please bring this completed form to your first appointment.

WELCOME TO OUR OFFICE

APP'T DATE ________ TIME ________

My appointment with Dr. Inouye is for

☐ ORTHODONTICS ☐ ORAL APPLIANCE THERAPY (SLEEP) ☐ TMD

PATIENT'S NAME ____________________

ADDRESS ____________________

____

AGE ________ DATE OF BIRTH ____________________ ☐ MALE ☐ FEMALE

FOR STUDENTS: SCHOOL ____________________ PARENTS' NAMES ____________________

____

HOME PHONE ____________ BUS PHONE ____________ CELL ____________

E-MAIL ADDRESS ____________________ SS# ____________________

PERSON RESPONSIBLE FOR ACCOUNT ____________________

EMPLOYED BY ____________________

BILLING ADDRESS ____________________

BEST PHONE NUMBER AND TIME TO CALL ____________________

PATIENT'S DENTIST NAME AND ADDRESS ____________________

____

PATIENT'S FAMILY PHYSICIAN'S NAME AND ADDRESS ____________________

____

I WAS REFERRED TO SEE DR. INOUYE BY ____________________

REASON FOR SEEKING TREATMENT or CHIEF COMPLAINT ____________________

____

A NOTE ABOUT YOUR INSURANCE:

Our Practice is a "Fee for Service" practice. At your initial visit, we will provide you with codes & guidelines to help you maximize your insurance benefits. For orthodontics, flexible payment plans are offered. We will be happy to assist you in preparing and submitting insurance claims. All insurance carriers, except for Delta, will send benefit payments directly to you.

Randall Inouye · DDS · MSD
735 B Cowper Street · Palo Alto · CA 94301
TEL · 650-321-3266