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Patient Information

Patient's Name _____ Date _____
Last First Nickname
Male / Female Birthdate _____ Age yrs. ____ mos. ____ E-Mail Address _____
Residence _____
Street City State Zip
Home Phone _____ Social Security # _____
If patient is a minor, accompanying parent/ guardian name _____
Last First Relationship to Patient
Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Marital Status
Residence _____
Street City State Zip
Mailing Address _____ E-Mail Address _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous address (If less than 3 yrs.) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Last First
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information

Insured's Name _____ Insured's Social Security # _____
Last First
Insurance Company _____ Group No. _____ Ins Co. Phone _____
Insurance Company Address _____
Street City State Zip
Insured's Employer _____ Insured's Birthdate _____
Do you have dual coverage? Y / N?
Insured's Name _____ Insured's Social Security # _____
Last First
Insurance Company _____ Group No. _____ Ins Co. Phone _____
Insurance Company Address _____
Street City State Zip
Insured's Employer _____ Insured's Birthdate _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____
Address _____
Street City State Zip

*To the best of my knowledge all information is correct.
I understand that where appropriate; credit bureau reports may be obtained.*

Signature (Parent's signature if minor) _____