



**Welcome to Kang Dental  
( Hebron )**

1628 W.Hebron Pkwy Suite 108, Carrollton TX 75010  
P: ( 972) 492-0002 F: (972) 492-0008

**Welcome to Kang Dental  
( H-Mart )**

2625 Old Denton Rd, Suite 101, Carrollton TX 75007  
P: ( 972) 242-3737

**PATIENT INFORMATION**

Please present form of identification and insurance (if applicable) to receptionists to be photocopied.

Dr  Mr  Mrs  Ms  Miss  Child

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we contact you by email?  Yes  No Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about us?  Newspaper  Family/Friend  Doctor  Other If yes, name: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

If you have insurance, please fill in the following information.

*Primary Insurance*

*Secondary Insurance*

Insurance Company	Insurance Company
Insurance Group#	Insurance Group#
Insurance Phone#	Insurance Phone#
Employer Name	Employer Name
Subscriber Name	Subscriber Name
Subscriber SSN	Subscriber SSN
Date of Birth	Date of Birth
Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other