Trang T. Le, D.D.S., Ltd.

Aesthetic & Comprehensive Dentistry

Patient Registration Form

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN _____ Driver's license Number: _____

Marital Status: *(Check one)*: S ☐ M ☐ D ☐ W ☐ Gender: *(Check one)*: M ☐ F ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Responsible Party Name: _____ SSN: _____ DL#: _____

Person Responsible for the Account: Patient ☐ Spouse ☐ Parent / Guardian ☐ (Specify Other): _____

Primary Dental Insurance Information:

Name of insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance CO. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Secondary Dental Coverage:

Do you have secondary dental insurance? Yes ☐ No ☐

If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. However, you are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Name of insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance CO. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Whom may we thank for referring you to our office? _____ Other: _____

Children under the age of 16 must be accompanied by an adult (guardian). 16 to 18 year olds must have guardian's written consent for treatment.

I acknowledge that I am responsible for all insurance co-payments on the day of service including services performed that are not covered by my insurance provider. As a courtesy, Dr. Le's office will submit dental insurance claims and accepts no responsibility for the amount, length, or scope of my provider's coverage. Should situations arise concerning my dental coverage, I understand it is my responsibility to contact my insurance company. If Dr. Trang T. Le is not a preferred provider for my insurance, I understand I may be responsible for payment in full the day of appointment; (In this case I will be directly reimbursed by my insurance company). Insurance coverage estimates provided to me by Dr. Trang T. Le's office are based on amounts reported by my insurance company at the time coverage information was requested and are subject to change. Financial responsibility: I agree to pay all finance charges, collection costs, attorney's fees, and any other costs incurred to enforce the collection of any outstanding amount.

My signature below indicates I understand and agree to all the above.

Signature _____ Date _____