TRANG T. LE, D.D.S., Ltd.

Family, Cosmetic, & Implant Dentistry

Patient Registration Form

Thank you for selecting our dental health team! We strive to provide you with the best possible dental care. To help us meet all your oral health care needs, please fill out the following forms, present your **insurance card** to the front desk, and ask us any questions you have should you need assistance filling out your forms.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ Driver's License Number: _____

Date of Birth: _____ Gender: ☐M ☐F

Marital Status (Check one): ☐Single ☐Married ☐Divorced ☐Widowed

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

Caretaker/Other Phone (Specify if "Other"): _____

Email: _____

Name of Responsible Party for Account: _____

Responsible Party Status: ☐Patient ☐Spouse ☐Parent/Guardian ☐Other: _____

Primary Dental Insurance Information:

Name of Insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN: _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance C.O. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Do you have secondary insurance? ☐Yes ☐No (If yes, please provide info below)

Secondary Dental Coverages:

Name of Insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN: _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance C.O. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

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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 of coverage information was requested and are subject to change.

Financial Responsibility: I agree to pay all finances charges, collection costs, attorney 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: _____

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Patient Medical and Dental History

Patient Name: _____ Date: _____

Although dental personal primarily treat dental conditions, your mouth is part of your entire body. Health problems you may or may not have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary Reason for Appointment: ☐Exam ☐Emergency ☐Consultation

Do you have a specific dental problem? (Please Explain): _____

Do you think you have active decay or gum disease? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Do you want to keep your remaining teeth? ☐Yes ☐No

Do you have clicking, popping, or discomfort? ☐Yes ☐No

Preferred Dentist or Provider: _____

Medical History:

Are you under the care of a physician? ☐Yes ☐No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Do you use tobacco? ☐Yes ☐No If yes, check one: ☐Smoke ☐Chew

Are you taking any medications, pills, or drugs? Please List: _____

Women (Are you)? ☐Pregnant ☐Nursing ☐Taking Oral Contraceptives

Are you ALLERGIC to any of the following?

☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics

☐Others: (Please be Specific) _____

Do you have, or have had, any of the following health conditions?

☐Angina	☐Emphysema	☐Recent Weight Loss
☐Heart Attack	☐Lung Disease	☐Eating Disorder
☐Heart Murmur	☐Tuberculosis	☐Diabetes
☐Mitral Valve Relapse	☐Hay Fever	☐Hypoglycemia
☐Congenital Heart Disorder	☐Sinus Trouble	☐Excessive Thirst
☐Pace Maker	☐Frequent Headaches	☐Kidney Problems
☐Chest Pains	☐Stroke	☐Renal Dialysis
☐Irregular Heartbeat	☐Fainting spells/Dizziness	☐Cancer
☐Artificial Heart Valve	☐Epilepsy/Seizures	☐Chemotherapy
☐High Blood Pressure	☐Alzheimer's	☐Radiation Therapy
☐Low Blood Pressure	☐Glaucoma	☐Leukemia
☐Excessive Bleeding	☐Arthritis	☐Liver Disease
☐Bruise Easily	☐Gout	☐Hepatitis A, B, or C
☐Rheumatic Fever	☐Artificial Joint	☐Drug Addiction
☐Hemophilia	☐Swelling of the Limbs	☐AIDS/HIV
☐Anemia	☐Cortisone Medication	☐Venereal Disease
☐Scarlet Fever	☐Ulcers	☐Shingles
☐Asthma	☐Frequent Diarrhea	☐Psychiatric Care
☐Easily Winded	☐Gastric Reflux Disease	☐Osteoporosis

Have you has any other illnesses not listed above? If yes, please list: _____

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Patient Medical and Dental History

Emergency Contact: _____ Relationship:_____ Phone Number:_____

Emergency Contact: _____ Relationship:_____ Phone Number:_____

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform my dental care provider of any changes in my medical status in a timely manner.

Signature: _____ Date: _____

TRANG T. LE, D.D.S., Ltd.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

*Obtaining payment from third party payers (E.g. my insurance company)

*The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. On the laminated sheet posted in our waiting room, we have provided a description of our policies. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how much protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Please list any dependent family members also covered by this acknowledgement:

I, _____ have READ and RECEIVED a copy of the office policies of Trang T. Le, D.D.S., Ltd. and agree to comply with the provisions.

Signature: _____Date: _____