

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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Family, Cosmetic, & Implant Dentistry

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?

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

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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: _____

Office Policies

Thank you for choosing the office of Trang T. Le, D.D.S., Ltd. for your dental care. We are committed to providing you with the best treatment and services available. To help us serve you, please take a moment to READ these office policies, SIGN and DATE below. If you have any questions or concerns, we will be glad to assist you.

Appointments: Please understand that once you make an appointment, that time is reserved for you. When an appointment is canceled with less than a 48-hour notice or if the appointment is not honored, we reserve the right to charge a \$50.00 fee for a missed appointment. In the event of unusual circumstances, exceptions will be made.

Financial: Payment is expected when services are rendered, unless other financial arrangements have been made. We accept Visa, MasterCard, American Express, Discover, Checks and Cash. There will be a \$30.00 fee for each Returned Check or Insufficient Funds.

Insurance: We will submit claims to **all** insurance companies. Insurance payments will be sent **directly** to you. Please keep in mind that reimbursement and dental coverage varies with in-network and out-of-network providers. Insurance policies are arrangements between you and your carrier. We recommend that you be familiar with your insurance policies so that we can help you obtain the maximum benefits.

Past due accounts may be forwarded to a collection agency. Patients would be responsible for any collection costs.

Thank you for your cooperation and entrusting your dental health with us.

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: _____