

# Faircity Mall Dental Care

## Patient Information

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Salutation (circle one): Mr. Mrs. Miss Ms Dr. Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birthdate: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_

Email: \_\_\_\_\_ May we send you reminders or information about new services? Yes No

Employment Status:  Full Time  Part time  Retired Student Status:  Full Time  Part time

Name and number of Preferred Pharmacy: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

What is your time preference for appointments (circle one)? AM PM Would you like to be on our short-notice list? YES NO

## Responsible Party/Policy Holder (Responsible party is the individual responsible for the bill or Insured)

Name of the Insured/Responsible Party: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

Soc. Sec (if different from above): \_\_\_\_\_ Date of Birth (if different from above): \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Employer Phone # \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Do you have secondary insurance? YES NO Insurance Group # \_\_\_\_\_

Insurance ID# \_\_\_\_\_

In the event that insurance does not cover all charges, may we charge your credit card? YES NO

If YES, credit card information:  Visa  MC  Discover # \_\_\_\_\_ Exp: \_\_\_\_\_

## CONSENT

1. The undersigned hereby authorizes doctor or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services approved in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made.
4. I understand that if bill is past due, collection charges may be incurred to my account.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I understand that there will be a charge of \$50 for failed appointments or cancellation without 48 hours notice if the office deems necessary.
7. I understand that claims are sent out as a service, but if insurance does not pay what was thought, it is the patient's responsibility.
8. I authorize this office to obtain any medical information about my dependents or me. I understand that this information will be kept in absolute confidence.
9. I hereby authorize payment of the dental benefits otherwise payable to me directly to Faircity Mall Dental Care ( Le & Tran, DDS)
10. I have been shown a copy of Faircity Mall Dental Care Notice of Privacy Practices and understand I can request a copy.
11. I give consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_ Parent or responsible party \_\_\_\_\_

Staff Member Signature \_\_\_\_\_ Date: \_\_\_\_\_

