

W E L C O M E

PATIENT INFORMATION

Name _____ Home Phone(_____) _____
Last First Middle
Address _____ City _____ State _____ Zip _____
Birthdate _____ Social Security # _____ Driver's License # _____
Occupation _____ Marital Status: *Single Married Divorced Widowed* Sex: *M F*
Employer _____ Work Phone(_____) _____
Employer Address _____ City _____ State _____ Zip _____
Whom may we thank for referring you? _____
IN CASE OF EMERGENCY, CONTACT: _____ Relationship _____
Home Phone(_____) _____ Work Phone(_____) _____

RESPONSIBLE PARTY

Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone(_____) _____
Driver's License # _____ Social Security # _____ Birthdate _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Date Employed _____
Employer _____ Work Phone(_____) _____
Employer Address _____ City _____ State _____ Zip _____
Primary Insurance Co. _____ Group # _____ Subscriber # _____
Secondary Insurance Co. _____ Group # _____ Subscriber # _____

CONSENT TO TREATMENT / AGREEMENT TO PAY

I hereby authorize the performance of dental services upon the above named patient. I also authorize any diagnostic films and photographs deemed necessary by the doctor to enable complete diagnosis and treatment.

I agree to pay for all services rendered. I understand that I may be charged a 1.5% per month finance charge if my balance goes beyond 90 days. I may also be charged for all legal fees and costs incurred if my balance goes to collection. In order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I understand that all fees incurred for dental treatment are my total responsibility, regardless of any insurance I may have. I assign dental benefit payments to be paid directly to Dr. Bao Nguyen from my insurance company. In the event that my insurance does not provide benefits or provides reduced benefit, I will be financially responsible to pay the agreed upon fee schedule.

Signature of Patient/ Parent or Guardian

Date