PATIENT REGISTRATION

First Name: **Last Name:** **Middle Initial:**

Preferred Name:

Patient Information:

Address:

City, State, Zip:

Home Phone: **Work Phone:**

Cell Phone: **□ I would like to receive text messages**

Sex:

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: **Drivers Lic#:**

E-mail: **□ I would like to receive email correspondences**

Patient Information (section 2):

Patient/ Parent Employed By: **Present Position:**

How Long Held:

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Spouse/Parent Employed By: **Present Position:**

How Long Held:

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Whom may we thank for this referral?

Primary Insurance Information:

Name of Insured:

Relationship to Insured:

Carrier/ Member/ Subscriber ID:

Insured Birth date:

Employer: **Insurance Company:**

Secondary Insurance Information:

Name of Insured:

Relationship to Insured:

Carrier ID #: **Insured Birth date:**

Employer: **Insurance Company:**

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist use and disclosure of my records or my child's records to carry out treatment, to obtain payment, and for those activity and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following person who are involved in my care (or my child's care) or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT'S or GUARDIAN'S SIGNATURE

_____ _____

Signature Date

Financial Agreement

I, _____, assign directly to Dr. Vin Vu, D.D.S all benefits, otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance. I agree to be financially responsible for services should they be considered "non-covered" or not medically necessary by my insurance company. All fees are due, in full, in advance or at the time of the appointment, regardless of any insurance involvement. Any payment that is not paid is subject to an interest charge of 12% a year.

Payment Options:

1. Cash or Local Checks 24 hours before an appointment 5% Courtesy Credit on most procedures.

2. Credit card (Master card, Visa, or Discover)

3. Third party financing through Care Credit.

4. Invisalign – 5% when paid on the day of patient acceptance.

*New patients are responsible for payment at first appointment.

*Patients with insurance are required to pay their portion at the time of service. Services that require lab work will require payment of half down and half at finish.

*Sedation appointments require payment the day before services are done.

*A Finance Charge of 1% monthly will be applied after 30 days on outstanding balances.

_____ _____

Signature Date