Mock & Tran Dentistry

Erich Mock, DDS, FAGD
Ann Tran-Dilay, DMD

New Patient Registration

First ____ Last ____ Preferred Name ____ Date of Birth ____

Street Address ____ Sex: Male Female N/A SSN ____

City ____ State ____ Zip ____ Primary Phone (H /W/C) ____ May we leave a detailed message? Yes No

E-Mail ____ Marital Status ____

Emergency Contact ____ Emergency Contact Phone ____

Employer ____ Employer Phone ____

Dental Insurance Information: (Please allow our front desk staff to make of copy of your insurance identification cards)

PRIMARY INSURANCE

Carrier: ____ Employer: ____ Name of Insured : ____

Insured's SSN: ____ Insured's DOB: ____

Member ID #:____ Group #: ____

SECONDARY INSURANCE

Carrier: ____ Employer: ____ Name of Insured : ____

Insured's SSN: ____ Insured's DOB: ____

Member ID #:____ Group #: ____

I hereby agree that all of the information I have provided is correct. I understand that as the signatory, that I am consenting for myself or my dependent to be seen by a provider in this dental office and that I am responsible for all financial matters attached to my account.

Patient or Legally Authorized Signature ____ Date ____

Printed Name if Signed on Patients Behalf ____ Relationship to Patient ____

Who may we thank for referring you to our practice? ____

Mock & Tran Dentistry

Financial Agreement

Patient Name: ____________________________ Date of Birth: _____________

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to being seen by one of our dental providers.

<u>If you have insurance:</u>

Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums. As a courtesy to our patients, we will send claims to your insurance company. **It is ultimately your responsibility to understand your insurance benefits and eligibility**.

We will do all we can to ensure your estimate is as accurate as possible, but we cannot guarantee payment or coverage of any procedures billed to your insurance company. **Any charges incurred that are not paid for by the insurance company is the responsibility of the patient.**

It is your obligation to ensure that our office has your correct contact, billing, and insurance information.

By signing below, you authorize the release of any information concerning you or your dependents dental care records for the purpose of evaluating and administering claims for insurance benefits. **If you do not authorize the release of information, we cannot and will not send claims to your insurance company.**

Payment is due at the time of service. All procedures will be billed to your insurance company, but a deposit or deductible may be collected for restorative treatment. The remaining balance will be billed to you for final payment. We may request that you contact your insurance company if payment is not made within the customary 60-day period.

If the patient is a minor: The consenting parent or legal guardian accompanying a minor is responsible for payment **at time of service**. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment.

Appointment cancellations made less than 24 hours prior may be subject to a cancellation fee of up to $60. Multiple failed appointments may result in being dismissed from the dental practice.

Accounts over 60 days may accrue interest at 1% per month or 12% annually. Should your account be turned over to collections, the collection fee will be added to your account.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Mock and Tran-Dilay Dentistry PLLC. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine.

____ _________________________

Name of Responsible Party Date

____

Signature of Responsible Party

Mock & Tran

Dentistry

HIPAA AUTHORIZATION FOR DISCLOSURE OF RECORDS

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have been informed of my right to request and secure a copy of Mock & Tran-Dilay Dentistry's Notice of Privacy Practices, which contains the complete uses and disclosures of my PHI, as well as my rights under HIPAA. I understand that the terms of the notice may change from time to time and that I may contact Mock & Tran at any time to obtain a current copy.

I understand that I have the right to request restrictions on how my PHI is used or disclosed to carry out treatment and payment. Mock & Tran are not required to agree to the requests, but are bound to comply should they choose to agree.

I understand that I may, at any time and in writing, revoke this consent. Any use or disclosure of my PHI prior to my revocation is not affected.

______________________________________ ______________

Patient or Legally Authorized Signature Date

______________________________________ ____________________________________

Printed Name Name and Relationship to Patient, if signed on their behalf

HIPAA AUTHORIZATION FOR DISCLOSURE OF RECORDS

I, the undersigned, give permission for my information to be shared with to following individuals. I understand that this may include appointment times and dates, planned and completed treatment, financial records, or other information that I may approve to be released. I understand that "sensitive information" can include, but is not limited to, discussing my medical history or disclosures of abuse. I understand that I can, at any time and in writing, revoke this permission or change what information may be shared.

Name & Phone Number	Share sensitive information?
1.____	O
2.____	O
3.____	O

______________________________________ _________________

Patient Signature Date

Mock & Tran Dentistry Confidential Health History

Patient Name: ______________________________ Date of Birth: ________________

Do you have, or have you had any of the following? (Please check any that apply)

- Anemia/ Bleeding Disorders
- Heart Attack Date:________________
- Heart Pacemaker
- Stroke Date:________________
- Autoimmune Disorder(s)
- Artificial joint replacement
  Date/Location: ______________________
- Heart surgery or valve replacement Date:_________
- High or low blood pressure (circle one)
- Kidney or Liver disease
- Hepatitis A B C (Circle One)
- Diabetes TYPE 1 or TYPE 2 (Circle One)
- Hypo or Hyperthyroid (Circle One)
- Arthritis Location: ____________________
- Herpes or cold sores
- Sexually Transmitted Disease
- Cancer or Tumor
  Date/Location:____________________
- Asthma
- Acid Reflux or GERD

Are you allergic to, or have you reacted adversely to any of the following?

- Latex
- Penicillin or other antibiotics
- Local anesthetics
- Codeine or other narcotics
- Sulfa drugs
- Aspirin
- Other:____
  ____

Please list current medications (including supplements)

____

____

____

____

____

____

Have you ever taken bisphosphonates (Fosamax, Boniva, Zometa) either orally or intravenously? *If yes, please list medication and length of use:*

____

Are you pregnant or plan to become pregnant?

Yes No

Due date: __________________

Do you currently or have you ever used tobacco products?

Yes No

For how long? _____________________

Do you currently use cannabis products? *Cannabinoids inhibit the efficacy of anesthetics, including local and nitrous oxide.*

Yes No

Are you required to Pre-medicate before any dental treatment?

Yes No

Medication: _________________

Do you have any other medical conditions not previously listed?

____

____

____

____

Primary Care Physician:

____

Primary Care Phone: _____________________________

Patient Signature: ________________________________

Date: _________________________