Franklin DENTAL

CALVIN NGUYEN DDS, PLLC

NEW PATIENT REGISTRATION

Patient's First Name _____Middle Initial_____Last Name_____

Address_____

City_____State_____Zip_____

DOB_____SSN_____

Email (for appointment reminders and communication) _____

Phone Home_____Cell_____Work_____

Employer_____Occupation_____

Emergency contact_____Relationship_____Phone_____

How did you hear about us_____

DENTAL INSURANCE

Subscriber's name_____DOB_____

Insurance Company_____Employer_____

ID# _____ Group#_____

Is patient covered by additional dental insurance? □ Yes □ No

Insurance Company_____ID#_____

Subscriber's name_____Group#_____

Welcome to Franklin Dental! We are pleased that you have chosen our office for your dental care. The staff is proud to have the opportunity to provide you with gentle, efficient, state of the art dental services. We hope to make your visits with us pleasant and comfortable as possible. Please take a moment to familiarize yourself with our office policies and procedures. Let the front office staff know if you have any questions/concerns.

DENTAL HISTORY

Reason for today's visit _____

Previous Dentist_____City/State_____

Last dental visit _____Last dental x-rays_____

Please check all that applies:

Bad breath	❑	Loose teeth	❑
Chew on one side of mouth	❑	Broken fillings	❑
Smoking	❑	Pain when brushing	❑
Dry mouth	❑	Orthodontic treatment	❑
Fingernail biting	❑	Periodontal treatment	❑
Grinding teeth	❑	Sensitivity to cold	❑
Bleeding gums	❑	Sensitivity to heat	❑
Gums swollen or tender	❑	Sensitivity to sweets	❑
Jaw pain or tiredness	❑	Sensitivity when biting	❑
Lip or cheek biting	❑	Ulcers	❑

How often do you brush? _____ How often do you floss? _____

MEDICAL HISTORY

Physician's Name_____

Abnormal bleeding w/extractions	❑	Glaucoma	❑	Respiratory disease	❑
AIDS/HIV	❑	Headaches	❑	Rheumatic fever	❑
Anemia	❑	Heart murmur	❑	Scarlet fever	❑
Arthritis, Rheumatism	❑	Hepatitis Type_____	❑	Shortness of breath	❑
Artificial Heart Valves	❑	Herpes	❑	Sinus trouble	❑
Artificial Joints	❑	High blood pressure	❑	Skin rash	❑
Asthma	❑	Low blood pressure	❑	Special diet	❑
Back problems	❑	Jaundice	❑	Stroke	❑
Blood disease	❑	Kidney disease	❑	Swollen joints	❑
Cancer	❑	Liver disease	❑	Swollen neck glands	❑
Circulatory problems	❑	Nervous problems	❑	Thyroid problems	❑
Heart disease	❑	Pacemaker	❑	Tonsillitis	❑
Cortisone treatments	❑	Pregnant	❑	Tuberculosis	❑
Cough, persistent or bloody	❑	Due date_____	❑	Tumor on head or neck	❑
Emphysema	❑	Diabetes	❑	Epilepsy	❑

List of medications you are currently taking:	**Circle any Allergies:**	
	Aspirin	Latex
	Barbiturates	Local Anesthetic
	Codeine	Penicillin
	Iodine	Sulfa
		Other:

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NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my treatment- directly and indirectly.
- Obtain insurance benefits and payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its Notice Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree upon my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

FINANCIAL CONSENT

I, the undersigned, hereby agree to pay to the above-named doctor all fees due for services rendered and/or expenses incurred by me, my spouse or children/dependents. Payment is to be made at the **time of service or incurring of expenses**.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments are my responsibility. Any assistance in this matter granted by the above doctor and staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation.

If this account is placed in the hands of an attorney for collection, I agree to pay reasonable attorney fees, all court costs and a finance charge of 1.5% percent per month (annual rate of 18%) on the unpaid balance will be added monthly. I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charge of $30 per returned check.

OFFICE GUIDELINES

1. Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for services at the end of each visit.

2. Our staff can tell you the **approximate estimated fee** for treatment prior to your next appointment.

3. Franklin Dental offers in- house payment plans upon request. Please ask us for more information.

4. If you have any questions regarding your insurance coverage or co-payment, please let us answer your questions before starting any dental treatment. Otherwise, we will assume that you are familiar with your dental plan coverage and limitations.

5. Payment and/or co-payment and deductibles are required in full at time of service. Any difference will be credited or billed after the insurance payment has been received.

6. Please be advised that any co-payment amount is just an **estimate** based on the information given to our office by your insurance at the time of verification. The information that is given over the phone by your insurance company is **not a guarantee of payment** by the insurance company and may actually differ from the estimate. Any insurance payment not received after 60 days becomes the responsibility of the patient for the full amount.

7. If an outstanding account has not been paid within 90 days, a monthly service charge will be added. If the account is not cleared, our office will turn over the account to our attorney for collective action.

8. We require at least **24 hours notice** for all appointment cancellations or rescheduling. This time is reserved for you; proper notification of a change allows us to schedule another patient. There will be a charge of **$50** without a cancellation notice the day before.

9. We accept cash, checks, Visa, MasterCard, Amex, and Discover.

I have read and understand the above policy and agree to be held financially responsible.

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have dental insurance coverage with above mentioned insurance(s) and assign to Dr. Calvin Nguyen all insurance benefits for services rendered. I authorize the use of my signature on all insurances submissions. Franklin Dental may use my health care information and may disclose such information to these insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Print Patient/Guardian's Name _____

Signature _____ Date _____