Hoa Van Tran, DDS
4111 Barbara Loop, Suite D-1
Rio Rancho, NM 87124
(505) 892-2010

Patient Registration

First Name:_____Middle Initial:_____ Last Name:_____
Preferred Name:_____Date of Birth_____ ☐ Male ☐ Female

Address:_____City,State,Zip:_____
Soc. Sec.:_____ Drivers License #:_____

Home Phone:_____ Cell Phone: _____
Work Phone:_____ext:_____ E-mail Address:_____
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Emergency Contact:_____ Contact# s):_____
Preferred Pharmacy and Location_____
How were you referred to our office?_____

Responsible Party (if other than patient)

First Name:_____Middle Initial:_____ Last Name:_____
Preferred Name:_____Date of Birth_____ ☐ Male ☐ Female
Adress:_____City,State, Zip:_____
Soc. Sec.:_____ Drivers License #:_____
Home Phone_____Cell Phone_____ Work Phone_____ext:_____

Insurance Information (if applicable)

Primary Insurance

Name of Insured:_____ Relationship to patient:_____
Insured Soc. Sec. #_____ Insured Date of Birth:_____
Employer:_____ Insurance Company_____
Address of Insurance Company:_____

Secondary Insurance

Name of Insured:_____ Relationship to patient:_____
Insured Soc. Sec. #_____ Insured Date of Birth:_____
Employer:_____ Insurance Company_____
Address of Insurance Company:_____

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Patient Name:_____ Date of Birth:_____

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for understanding the following questions.

Are you currently under a physicians care? ☐ yes ☐ no
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no
If yes, please explain:_____

Have you ever had a serious head or neck injury? ☐ yes ☐ no
If yes, please explain:_____

Are you taking any medications, pills, or drugs? ☐ yes ☐ no
If yes, please list medication, dosage, and frequency:_____
_____
_____

Do you take, or have taken Phen-Fen or Redux? ☐ yes ☐ no
Are you on a special Diet? ☐ yes ☐ no
Do you use tobacco? ☐ yes ☐ no
Do you use controlled substances? ☐ yes ☐ no

Women: Are you:
☐ Pregnant (if so, please list due date)_____ ☐ Trying to get pregnant
☐ Nursing ☐ Taking Oral Contraceptives (is so which one)_____

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Local Anesthetics
☐ Other- Please Explain:_____

Do you snore? ☐ yes ☐ no
Do you gasp for air during the night? ☐ yes ☐ no

Medical Information Continued on next page

Do you have or have you had any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Has a physician ever told you to take an antibiotic premedication prior to any dental treatment? ☐ yes ☐ no

Have you ever had any serious illnesses not listed above? ☐ yes ☐ no

If yes, please explain: _____

COMMENTS:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Responsible Party _____

Date

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Acknowledgement of Privacy Rights

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Patient Name:_____Date_____

Signature:_____
Relationship to Patient:_____

Dependent family members also covered by this acknowledgement:

_____

Professional Services and Fees

Dr. Tran and his staff are committed to providing you with the best care possible and welcome the opportunity to discuss fees pertaining to your treatment needs. Your clear understanding of both your treatment and your financial responsibility is very important to us.

Payment for dental treatment is due and payable at the time the service is rendered. For your convenience we accept cash, personal checks (in-state), Visa, MasterCard, and Discover. We also have out-of-office financing available which, after approval, offers affordable monthly payments.

Once we have discussed treatment options and appointment schedules with you, you will be given an estimate and asked to make the necessary financial arrangements with our Business Manager.

Should we receive a returned check from your banking institution, an insufficient funds charge of $20.00 will be applied to your account. If a balance remains on your account once an insurance claim has been finalized a courtesy statement is forwarded to you and 25 days will be allowed for you to pay the remaining balance. If this balance is not paid in the allowable time frame and a second (or subsequent) statement is generated, a non-reversible service charge will be added to the account. The services will be a periodic rate of 1.5% per month (or a minimum charge of $5.00 for a balance under $200.00), which is an annual rate of 18%, applied to the last month's balance. In case of default of payment, the responsible party for the account is responsible for all legal interest on the balance due, together with any collection costs and reasonable for all legal interest to pursue collection of the account.

In the case of default of payment, I understand I am responsible for all legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts.

I understand and acknowledge that I have read, understand and agree to the aforementioned policies.

_____ _____

Signature Date

Acknowledgment of General Office Policies

Informed Consent:

I understand that I will be informed of my dental ailment, treatment options, benefits, substantial risk and consequences of limited or non-treatment. I consent to and authorize dental services to be preformed. I understand that at any time I may terminate or postpone dental treatment.

Photograph Consent:

I give permission to Hoa Van Tran, DDS to use my photographs for educational or insurance purposes.

Broken Appointments:

Our office understands that life is busy for all of us and there are times when circumstances arise that are beyond one's control. However, when an appointment is reserved with our office and patients fail to come in for that appointment or cancel with little to no notice, we still have to pay our staff and all the hard costs involved with a dental appointment. Not to mention that we have other patients waiting to be seen earlier, if possible, that could have utilized the time.

Since we do not wish to increase fees to cover these costs, thus penalizing all patients for the actions of others, there will be a flat fee assessed to all accounts when an appointment is broken. The fee assessed for a broken appointment with Dr. Tran will be $50.00 per hour and $30.00 per hour with the hygiene department.

I understand that the Dental Office reserves the right to charge for each broken appointment if 24 hours notice is not given. I understand that leaving a message after hours for the following day does not constitute 24 hours since the Dental Office will not receive the message until 8:00 a.m. the next working day. I also understand that the Dental Office will attempt to reach me to remind me of my appointment as a courtesy, but that the appointment is considered confirmed when it is made.

Authorization

I hereby authorize Dr. H. V. Tran's office to administer such medication and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on my dental and medical histories is correct to the best of my knowledge. I grant the right to Dr. H. V. Tran to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I understand and acknowledge that I have read, understand and agree to the aforementioned policies.

_____ _____

Signature Date

Dental Insurance

If you have dental insurance, we will help you receive your maximum allowable benefits. We will gladly discuss your treatment and answer any questions relating to your insurance to the best of our ability. As a courtesy, we will file your claims, but will not accept responsibility for negotiating any settlement on disputed claims.

Our fees are generally considered to fall within the acceptable (reasonable and customary) range for most insurance companies. This does not apply when we file as an out-of-network provider or when insurance companies reimburse on an arbitrary "Fee Schedule", which bears no relationship to the current standard and cost of care in this area.

The objective of and insurance company is to collect premiums and not pay out any more than necessary on your behalf. Please remember that not all services are benefit of your contract. Insurance companies base their treatment expectations on dental treatment considered acceptable in the 1950's and 1960's. These expectations can change from one year to the next based on the payment made by them the previous year.

If a balance remains on your account once an insurance claim has been finalized a courtesy statement is forwarded to you and 25 days will be allowed for you to pay the remaining balance. If this balance is not paid in the allowable time frame and a second (or subsequent) statement is generated, a non-reversible service charge will be added to the account. The services will be a periodic rate of 1.5% per month (or a minimum charge of $5.00 for a balance under $200.00), which is an annual rate of 18%, applied to the last month's balance. In case of default of payment, the responsible party for the account is responsible for all legal interest on the balance due, together with any collection costs and reasonable for all legal interest to pursue collection of the account.

I understand that my dental insurance is a contract between my insurance carrier and me and **NOT** between the insurance carrier and Dr. Hoa V. Tran: therefore, I am still responsible for **ALL** dental fees. I understand that I will be charged for all dental treatment and that any payment received by the Dental Office from my insurance company will be credited to my account or refunded to me if I have paid the dental fees incurred.

I understand and acknowledge that I have read, understand and agree to the aforementioned policies.

_____ _____

Signature Date