Adult Patient Registration

PHAMILY DENTAL CARE

(Please Print) Date: _____

Patient Information

Name: _____
Last Name First Name Middle Initial Preferred Name

Sex: [ ] M [ ] F Age:_____ Birthdate: _____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Primary Address: _____

_____
City State Zip Code

Email Address: _____ _____ _____
Home Phone Cell Phone

I consent to receive text messages from the office of Dr. Bryan Q Phamnguyen, DDS,PA: [ ] Yes [ ] No

Emergency Contact Name/Relationship:_____ Phone:_____

Referral Information**:** Whom may we thank for referring you to our practice: _____

Primary Dental Insurance

(If the information is the same as above, please put "same")

Employed by:_____ Occupation: _____

Person Responsible for account: _____
Last Name First Name Middle Initial

Relationship to Patient: _____ Birthdate: _____ Soc Sec: _____

Member/Patient/Subscriber ID: _____

Primary Address (If different from Patient's): _____

_____ _____
Primary Phone Number City State Zip Code

Assignment & Release of Dental Insurance(s)

I understand, certify that I (or my dependent) have insurance with (name of Insurance Company(ies)_____ and assign directly to Dr. Bryan Q. Phamnguyen all benefits, if any other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submission whether manual or electronic.

_____
Patient Signature Relationship to Responsible Party Date

Date of Last Dental Visit: _____ **Reason for this visit:** _____

Health History

[ ] AIDS/HIV	[ ] Epilepsy	[ ] Pregnant? Due: _____
[ ] Anemia	[ ] Fainting/Dizziness/Vertigo	[ ] Radiation Therapy
[ ] Arthritis, rheumatism	[ ] Glaucoma	[ ] Respiratory Disease
[ ] Artificial Heart Valves	[ ] Headaches	[ ] Rheumatic Fever
[ ] Artificial Joints	[ ] Heart Murmur	[ ] Scarlet Fever
[ ] Asthma	[ ] Heart Problem	[ ] Shortness of Breath
[ ] Back Problems	[ ] Hepatitis, Type: _____	[ ] Sinus Trouble
[ ] Birth Control Medication	[ ] Herpes	[ ] Skin Rash
[ ] Bleeding Abnormally	[ ] High Blood Pressure	[ ] Stroke
[ ] Blood Disease	[ ] High Cholesterol	[ ] Swollen Feet/Ankles
[ ] Cancer: _____	[ ] History of Infective Endocarditis	[ ] Swollen Neck Glands
[ ] Chemotherapy	[ ] Jaundice	[ ] Thyroid Problems
[ ] Circulatory Problems	[ ] Jaw Pain	[ ] Tonsillitis
[ ] Congenital Heart Defect/Disease	[ ] Kidney Failure	[ ] Tuberculosis
[ ] Cough, Persistent or Bloody	[ ] Liver Disease	[ ] Tumor/Growth (Head/Neck)
[ ] Diabetes	[ ] Low Blood Pressure	[ ] Ulcer/GERD/Acid Reflux
[ ] Drug Misuse, Rx or Other	[ ] Nervousness/Anxiety	[ ] Weight Loss
[ ] Emphysema	[ ] Pacemaker	[ ] None

Medication: List any medications you are currently taking

[ ] Blood Thinners (i.e, Plavix, Xarelto, Asprin): _____ Other: _____

[ ] Bisphosphonate (i.e, Fosamax, Prolia, Boniva): _____ [ ] None

***Pharmacy Name/Address/Phone#:**_____

Allergies:

[ ] Aspirin	[ ] Latex	[ ] Sulfa
[ ] Codeine	[ ] Local Anesthesia	[ ] None
[ ] Iodine	[ ] Penicillin	[ ] Other: _____

*Please indicate your go to pharmacy even if you are not taking any medication at the moment.

- **Name of Primary Care Physician:** _____
  Address:_____
  Phone #: _____

- Have you ever had any complication following dental Treatment? [ ] Yes [ ] No
  If yes, please explain: _____

- Have you been admitted to a hospital or need emergency care during the past two years? [ ] Yes [ ] No
  If yes, please explain: _____

- Any other health problem that needs further clarification: _____
  _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctors at the next appointment without fail.

Patient/Guardian Signature:_____ **Date:**_____

HIPAA PRIVACY

PHAMILY DENTAL CARE

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have read the entirety of this Notice and been explained my rights in regard to privacy practices. I also understand that I have the right to request an exact copy of this acknowledgment that I am signing.

I understand that **Dr. Bryan Q. Phamnguyen** and his staff may use and disclose any necessary personal health information (e.g. my name, address, subscriber identification number) to another party to permit the location to perform its administrative duties, provide me with dental care services and products, process my dental benefit claims and communicate with me regarding dental care services provided by the location (e.g. exam reminders, information about services/products provided by the location).

I also understand that the office of **Dr. Bryan Q. Phamnguyen** will **not** disclose my personal information to any third parties without my **documented** consent nor will they sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that the location may submit my dental benefit claims to my plan sponsor or health plan to receive reimbursement directly for the dental services and products that I have received from the location.

Patient/Guardian Signature: _____ **Date:** _____

AUTHORIZATION FORM FOR RELEASE OF INFORMATION TO FAMILY MEMBER/FRIEND

I, _____ (Patient's Name Full Name), give permission to my dental care provider, Phamily Dental Care, to disclose and release my complete protected health/dental information (including but not limited to diagnosis, treatment, appointments, and billing) described below to:

NAME(S):	RELATIONSHIP/PHONE #:
_____	_____
_____	_____
_____	_____
_____	_____

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic". Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide sure that you will be able to keep it. Mornings scheduled at 8:00AM or afternoons at 1:00PM are best for more complicated procedures.

Our office will call you two days in advance to remind/confirm your appointment as a ***courtesy***. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of **$50.00 (FIFTY)** for broken appointments or cancellation with less than 24 hours' notice.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Please note, patients who miss more than 3 appointments within a 12 months period may be required to pre-pay or any future appointments. Patients with history of cancelled or broken appointments may result in dismissal from our practice

Patient/Guardian Signature: _____ Date: _____

Written Financial Policies and Agreement

Thank you for choosing Dr. Bryan Q. Phamnguyen, D.D.S., P.A. and his team at Phamily Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering easy and convenient payment options.

Payment is required prior to the completion of your treatment no later than the day the services are rendered. If you choose to discontinue care before your treatment is complete, a refund may be determined upon review of your case.

Payment Options: Patients may choose from the following payment options: Cash, Money Order, VISA, MasterCard, Discover, and, as well as dental insurance.

Payment In Full Discounts: We offer a 10% courtesy adjustment for payment in full on treatment plans of $1,500 or more when a patient pays with cash (bills) and completes the payment prior to the treatment.

Estimated Insurance Payments: We realize that understanding your insurance coverage can be quite challenging.

Our Courtesy Services: If you have dental insurance, we will contact your insurance plan to help you determine your estimated coverage. We will review any amounts your insurance is not expected to pay and inform you as to your estimated responsibility. These amounts are due the day services are rendered. Although we do not participate in all dental insurance plans, with accurate insurance information, we will be glad to file your claim as a courtesy to you. Insurance claims are filed within one business day of your visit and are filed electronically for the fastest turnaround.

Our expectations of YOU: We encourage you to understand your individual policy. Some dental insurance policies restrict payment for some services, use restricted fee schedules, and exclude some procedures based on conditions outside our control.

- We ask that you understand that our treatment recommendations will always be based on providing the best oral health care for our patients, and not on what an insurance company will or will not cover. We will help educate you on your dental needs and finance options so that you may make the best decision for your care.
- We also ask that you keep us updated on any changes to your insurance coverage.
- Patients who have insurance that will reimburse them only should come prepared to pay for their services in full at the time of service.
- We ask that you understand if payment is not received by your carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
- Please be prepared to leave a credit card on file for any balance that may be due.

If your insurance coverage is cancelled or changes during treatment, you will be responsible for the amount that the insurance company has not paid.

Please contact us directly if you need to determine if Dr. Bryan Q. Phamnguyen is considered a preferred provider for your plan.

Past Due Finance Charges and Penalties: Monthly finance charges of 1.5% (minimum fee is $1) will be added to accounts which are over 60 days past due.

Thank you for understanding our financial and insurance policies. If you have any questions do not hesitate to ask us as we are here to assist you.

Patient/Guardian Signature: _____ Date: _____