PATIENT INFORMATION FORM

Patient Name: First______________________ MI _____ Last________________________ Nickname_________________

Address: ____ City/State: ________________________Zip:_____________

Phone: Home: _________________________ Work: ________________________ Mobile: ________________________

Date of Birth: __________________________ Social Security # ______ -- _____ -- ______ Sex: • Male • Female

Employer: ___________________________________ Occupation: ____________________ Phone: __________________

Emergency Contact: __________________________ Relationship to Patient: ___________ Phone: _________________

Is the patient a Minor? : •Yes •No Name of Responsible Party: ____
Relationship to Patient: • Parent • Guardian • Other

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. ***However, you may consent to receive email from us regarding your treatment.*** *We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.*

- I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
- I do not consent to receiving any information via email. I understand that I can change my mind and provide consent at a later time.

Email Address: ____

Appointments: Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. We require at least 48 hours advanced notice of any cancellation/rescheduling to avoid a fee of $75 with the doctor. As a courtesy, we make every effort to remind patients of their appointments either by telephone or email, but please do not depend on this courtesy.
Your Preferred Method of Courtesy Reminders: • Home • Work • Mobile • Email

---

Dental Insurance Plan Information

Primary Dental Insurance Company: ____ Phone: _______________________
Primary Subscriber's Name: ____ Date of Birth: _______________________
ID Number: _________________________________ Patient Relationship to Insured: _______________________________
Secondary Dental Insurance Company: ______________________________________ Phone: ________________________
Primary Subscriber's Name: ____ Date of Birth: _______________________
ID Number: _________________________________ Patient Relationship to Insured: _______________________________

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to Dr. Khanh V. Nguyen, DDS otherwise payable to me. **__________ (initial)**
As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage. Dental insurance differs from medical insurance and it is important to be aware of the following:

• Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy. All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is provided.

The information that I have provided above is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. ________ (initial)

I hereby acknowledge that a copy of the HIPAA Notice has been made available to me. I have been given the opportunity to ask any questions that I may have regarding this Notice. __________(initial)

Signature: **Date:**