Patient Registration Form
Thank you for selecting our Dental Healthcare team!
We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information *Date*____________________

First Name__________________ LastName____________________ DOB____________

Address______________________ City_______________ State____ Zip____________

Home Phone_______________ Cell Phone_______________ Alternate Phone____________

Email Address______________________ Relationship to Subscriber: Self Spouse Child Other

Person to contact in case of an emergency____________________ Phone number______________

Responsible/Insured Information ***Please have your insurance card/picture ID so we may take a photo copy***

First Name__________________ LastName____________________ DOB____________

Address (if different)______________________ City______________ State_____ Zip_______

Employer____________________________ Telephone Number_______________________

Dental Carrier Name________________________ Subscriber ID________________________

Group Number___________________________ Social Security________________________

Responsible/Secondary Insured Information

First Name__________________ LastName____________________ DOB____________

Address (if different)______________________ City______________ State_____ Zip_______

Employer____________________________ Telephone Number_______________________

Dental Carrier Name________________________ Subscriber ID________________________

Group Number___________________________ Social Security________________________

Getting to Know You

Last Dental Visit: 0-6 months____ 6-12 months____ 1-5 years____ Over 5 years____ Over 10 years____

How did you hear of our Office? Location____ Insurance Company____ Referred by family/friend______

Whom may we thank for referring you?____

What is your concern?____

Are you happy with the appearance of your smile? Yes____ No____

Does the Dentist visit make you nervous? Yes____ No____ Somewhat____

Would you be interested in replacing old silver fillings with white material fillings? Yes____ No____

(over please)

Patient Medical History

Question			Question		
Are you under the care of a physician now?	yes	no	Are you allergic or have you had any reactions to the following?		
If you have been hospitalized for any surgical procedure or serious illness in the past five years please explain.			Local Anesthetics [e.g. Novocain]	yes	no
			Penicillin or any other antibiotics	yes	no
			Barbiturates	yes	no
Are you taking any medications, including non-prescriptions? List medications	yes	no	Sedatives	Yes	no
			Iodine	yes	no
			Aspirin	yes	no
Have you ever taken Fen-Phen / Redux?	yes	no	Any Metals [e.g. nickel, mercury, etc.]	yes	no
Do you use tobacco?	yes	no	Latex Rubber	yes	no
Do you use or have a history of using controlled substance?	yes	no	Other [please explain]	yes	no
Are you wearing contact lenses?	yes	no	*Women only* ** Are you pregnant or think you may be pregnant?	yes	no
Have you had a persistent cough lasting more then 3 weeks?	Yes	no	*Women only* **Are you nursing?	yes	no
			Women only **Are you taking oral contraceptives?	yes	no

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

AIDS / HIV	yes	no	Cortisone Treatments	yes	no	Jaundice	yes	no	Shortness of Breath	yes	no
Arthritis, Rheumatism	yes	no	Cough, persistent or bloody	yes	no	Jaw Pain	yes	no	Sinus Trouble	yes	no
Artificial Heart valves	yes	no	Diabetes	yes	no	Kidney Disease	yes	no	Skin Rash	yes	no
Artificial Joints	yes	no	Emphysema	yes	no	Liver Disease	yes	no	Special Diet	yes	no
Asthma	yes	no	Epilepsy	yes	no	Low Blood Pressure	yes	no	Stroke	yes	no
Back problems	yes	no	Fainting or Dizziness	yes	no	Mitral Valve Prolapse	yes	no	Swollen Feet or Ankles	yes	no
Bleeding Abnormally	yes	no	Glaucoma	yes	no	Nervous Problems	yes	no	Swollen Neck Glands	yes	no
Blood Disease	yes	no	Headaches	yes	no	Pacemaker	yes	no	Thyroid Problems	yes	no
Cancer	yes	no	Heart Murmur	yes	no	Psychiatric Care	yes	no	Tonsillitis	yes	no
Chemical Dependency	yes	no	Heart problems	yes	no	Radiation Treatment	yes	no	Tuberculosis	yes	no
Chemotherapy	yes	no	Hepatitis type___	yes	no	Respiratory Disease	yes	no	Tumors	yes	no
Circulatory problems	yes	no	Herpes	yes	no	Rheumatic Fever	yes	no	Ulcer	yes	no
Congenital Heart Lesions	yes	no	High Blood Pressure	yes	no	Scarlet Fever	yes	no	Venereal Disease	yes	no

In general how would you rate your health condition? Excellent ___ Good ___ Fair ___ Poor ___ How much do you weigh? ________________

Have you ever been told by any health professional you need to take antibiotics prior to dental treatment? Yes___ No___

Do you have any additional health issues, conditions or concerns? No _____ Yes _____ If yes please explain________________________

Patient Dental History

Name and Location of previous dentist________________________________ -Date of last exam________________

How long ago was a full series of dental xrays taken? (this includes a panoramic view)________________________

Reason for today's visit?________________________________

Do your gums bleed while brushing or flossing?	yes	no	Do you have any sore or lumps in your mouth?	yes	no	Do you bite your lips or cheek	yes	no
Are your teeth sensitive to hot & cold?	yes	no	Have you ever injured your head, neck or jaw?	yes	no	Have you had orthodontic treatment?	yes	no
Are your teeth sensitive to sweet & sour?	yes	no	Do you have frequent headaches?	yes	no	Have you ever had difficulty with extractions?	yes	no
Do you feel pain in any of your teeth?	yes	no	Do you clench or grind your teeth?	yes	no	Do you floss regularly?	yes	no
Do you ever have difficulty opening, closing or chewing with your jaw?	yes	no	Would you like to get instruction on proper brushing and flossing techniques?	yes	no	Do you get unpleasant smells or taste in your mouth?	yes	no

Authorization and Release: *I certify that I have read and understand the above information. To the best of my knowledge, the above questions hav een answered accurately. I understand that providing incorrect information can be precarious to my health. I authorize First Lathrop Dental to release any information, includ ll records of diagnosis and treatment for me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Fir athrop Dental insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree that I am financ esponsible for all charges, included but not limited to dental service deemed routine, elective or cosmetic by my insurance company and/or any co-pays, deductibles, co-insura r non covered service .I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize First Lathrop Dental and the designated staff rovide the necessary and desirable procedures for my dental care or the dental care of my minor child. I acknowledge that no guarantee or assurance has been made as to th esults to be obtained. I acknowledge that I am aware that I could be charged $50.00 for missing or canceling an appointment without 48 hour notice.*

X________________________________ ***Date***________________________

Signature of Patient [or parent/guardian if minor]

1st Lathrop Dental

OFFICE POLICIES AND AUTHORIZATIONS

We are delighted you have chosen our practice to provide for your dental care. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding provider and patient.

Listed below are some of our office policies please review carefully, initial where indicated and sign below. If you have any questions please do not hesitate to ask.

FEE AND PAYMENTS

We will always inform you of the fees for any treatment you will receive in our office. We are happy to bill your insurance company as a courtesy to you. Although we will estimate what your insurance company will pay, it is the insurance company that makes the final determination of benefits. You are responsible for any amount left unpaid by your insurance company. While your claim is being processed you will receive monthly statements of your account. If you paid an estimated portion at the time of service, we do not expect payment from you unless your insurance has delayed payment over 60 days. We reserve the right to charge interest of 1% per month to all balances over 60 days.

We will collect what we estimate to be your estimated portion at the time of the service unless otherwise agreed upon prior to beginning treatment.

______________(initial)

DENTAL RADIOGRAPHS

Dr. Tran and our team work and our team work very hard to give the very best in patient care. Part of this means keeping up with the standard of care as set by the American Dental Association. The ADA recommends dental radiographs to be taken every 6 to 24 months. Dr. Tran understands that some patients have concerns about dental radiographs, that is why we have invested in Digital Radiographs which use up to 90% less radiation. We feel the standard of care in our office should keep with the standard of care set by the ADA, but also take into consideration the personal needs of our patients. This is why we require patients under our care to have radiographs taken at least once every two (2) years. The number of radiographs to be take will be determined by the amount of teeth and the conditions of the patients mouth. If you have any questions about this standard of care please feel free to discuss it with Dr. Tran or any member of our team.

______________(initial)

ASSIGNMENT OF BENEFITS

I hereby authorize assignment of my insurance benefits directly to Dr. Tran for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company.

______________(initial)

CANCELLATION POLICY

We respect that your time is valuable and we will exclusively reserve appointment times for you and attempt to always see you in a timely manner. We consider appointments confirmed the day they are made. We do understand that sometimes appointments may need to be rescheduled due to unforeseen occurrences or emergencies but we do ask for a 2-business day notice for any schedule changes. We reserve the rights to charge 75.00 for a missed appointment with less than 2-business days notice.

______________(initial)

AUTHORIZATION FOR POLICY

I authorize the doctor and team to perform any necessary services needed during diagnosis and treatment. I also authorize release of any information required to facilitate payment by my insurance or third party payers.

______________(initial)

____

Patients Signature

____

Date

1st Lathrop Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

1st Lathrop Dental

FAMILY & COSMETIC DENTISTRY

Financial Policy (for all patients)

Thank you for choosing us as your dental care provider. The following describes our Financial Policy. Our office is committed to providing you with the best possible care. **Your understanding of our Financial Policy is an essential element of your care and service.** If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered. We accept cash, debit card, and for your convenience Visa, MasterCard, American Express, Discover and 3rd Party financing through Care Credit. Please be advised that we **do not** accept check payments in the office. **Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service.** Payment in advanced may be required to reserve chair time.

Deposit Policy:

Due to the extensive amount of time our staff and doctors devote to preparing, we do require a deposit of half the fee/co-pay to make your appointment reservation. ____________ initials

Appointment Policy (for all patients)

We will work hard to accommodate appointments that fit with your schedule and dental needs. **We ask that you let us know about any changes 48 hours in advance. We do understand that life happens, but any missed appointments without the 48 hour call or last minute cancelation may be subject to a $50 short/ no notice fee. Habitual missed appointments or last minute cancelations are grounds for dismissal from the practice.** ____________ Initials

I have read and understand the Financial Policy and Appointment Policy for 1st Lathrop Dental. I agree to abide by these policies.

Patient/Guardian Signature: ____________

Printed Name: ____________

Date: ____________

TEL: 209.858.4700 • FAX: 209.858.4704 • 15136 HARLAN ROAD • LATHROP, CA 95330

Insurance Policy and Assignment of Benefits (for patient with dental insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date carrier information, restrictions of your policy, and billing information. If your insurance company has not paid your claim in full within 45 days the remaining balance will automatically become patient responsibility.

__________________ Initials

I hereby authorize my primary and/or secondary insurance company to make payments directly to 1st Lathrop Dental. I have read and understand the Insurance policy for 1st Lathrop Dental. I agree to abide by these policies.

Patient/ Guardian Signature: ____________________________

Print Name: ____________________________

Date: ____________________________