Vi Truong-Mai, D.D.S. Date _____

Patient Information

The information requested below will allow us to correctly establish and/or update your account. We appreciate your help in making this information as accurate and complete as possible.

Please Print:

1. PATIENT

Name _____ Birthdate _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ ☐ Male ☐ Female

Cell Phone _____ Email _____

(If patient is a child, please go next to Section 3.)

Employed By _____

Address _____ Phone _____

_____ Position _____

Drivers License # _____ Social Security # _____

(If you are single, please go next to Section 4.)

2. SPOUSE

Name _____ Birthdate _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ ☐ Male ☐ Female

Employed By _____

Address _____ Phone _____

_____ Position _____

3. MINORS ONLY

Name of Father _____	Name of Mother _____
Address _____	Address _____
_____	_____
Birthdate _____	Birthdate _____
Phone _____	Phone _____
Employed By _____	Employed By _____
Address _____	Address _____
_____	_____
Work Phone _____	Work Phone _____
DL # _____	DL # _____
SS # _____	SS # _____

4. In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

TURN OVER →

5. Person Responsible for Account _____

   Address if Different _____

6. Nearest Relative or Friend not living with you _____ Phone _____

7. Do you have **Dental Insurance?** ☐ Yes ☐ No

   If Yes, complete the following:

	Primary Insurance	Secondary Insurance
Person Policy Issued to	_____	_____
Relationship to Patient	_____	_____
Social Security #	_____	_____
Name of Insurance Co.....	_____	_____
Insurance Company Address: Street	_____	_____
City, State, Zip Code	_____	_____
Group #	_____	_____
Policy # / Identification #.....	_____	_____
Birthdate.....	_____	_____
Date Employed.....	_____	_____

We need the above information so that we can help you obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a "pre-determination" of benefits or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

LET'S GET ACQUAINTED

Whom may we thank for referring you to our office?

To help your doctor know you a little better you may provide the following optional information:

What are your special interests and/or hobbies?

How long have you lived in the area?

Authorization and Release

I authorize the dentist and the staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____