MODERN FAMILY DENTAL

CONFIDENTIAL PATIENT REGISTRATION

A. Patient Information

Who can we thank for referring you to us?_____

Who is financially responsible for your account? ☐ I am ☐ Someone else is (their information is entered in section B)

First Name:_____ Last Name:_____ Middle Initial:____ Preferred name:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone: _____ Cell/Pager (circle): _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date:_____ Social Security Number:_____-_____-_____

Your Social Security Number is required to bill your dental insurance. We also cannot bill you for any services without the number in our files.

E-mail:_____(This is just for appointment confirmations & communications you request – not spam!)

B. Financially Responsible Person

If the financially responsible person is the patient, skip to section C.

First Name:_____ Last Name:_____ Middle Initial:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone: _____ Cell/Pager (circle): _____

Birth Date:_____ Social Security Number:_____-_____-_____

C. Insurance Information

Primary Insurance (If you have secondary insurance, please let us know.)

Name of Insured:_____	Insured Birth Date:_____
Insured Social Security or Member ID #:_____	Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer:_____	Insurance Company:_____
Employer Address:_____	Insurance Address:_____
Emp. City/State/Zip:_____	Ins. City/State/Zip:_____
Group Name:_____	Group Number:_____

- I hereby authorize Dr. Hao C. Tran or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Tran to perform any mutually agreed upon treatment and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I understand that EVERY dental procedure carries some risk. We will always strive to inform you of these risks in advance, but not necessarily for every single routine procedure. It is possible that even a "low-risk routine procedure" like a simple filling can evolve into something more expensive, complicated or painful than we initially predicted. This is why we would be happy to recite any known risks associated with any procedure(s) relevant to you upon request.
- I understand that Dr. Tran and his staff reserve appointment times just for me. If I cancel or don't come to an appointment without giving at least TWO (2) business days' notice, the appointment time might remain unfilled and this would impact the practice tremendously. This is why there is a charge for appointments canceled with too little notice. By signing below, you acknowledge and agree to all of the above terms.

Full Name:_____ Date:_____

Signature of patient, parent or guardian:_____

MODERN FAMILY DENTAL

CONFIDENTIAL MEDICAL HISTORY

PATIENT FULL NAME:_____ DATE OF BIRTH:_____

Please write in the name, number and city of your physician or another emergency contact person: _____

Are you under the care of a physician? (Other than routine exams) ☐ Yes ☐ No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? (Other than a C-section or childbirth) ☐ 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? Include non-prescription drugs like "Aspirin", herbal medications like "St. John's Wort" or *any* recreational drugs. ☐ Yes ☐ No If yes, which ones?_____

Do you take, or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, please explain:_____

Do you use tobacco products? ☐ Yes ☐ No If yes, how much (e.g. "1/2 pack a day"):_____

Women, are you: ☐ Pregnant / trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

I am allergic to:

☐ "NSAID" drugs (e.g. Advil, Aspirin) ☐ Penicillin or Amoxicillin ☐ Codeine ☐ Acrylic or Metals ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Shellfish ☐ Other?:_____

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

☐ Y ☐ N AIDS / HIV Positive	☐ Y ☐ N Cortisone Medicine (pills you swallow, not creams)	☐ Y ☐ N Hemophilia	☐ Y ☐ N Radiation Treatments
☐ Y ☐ N Alzheimer's Disease	☐ Y ☐ N Diabetes	☐ Y ☐ N Hepatitis A	☐ Y ☐ N Recent Unexpected Weight Loss
☐ Y ☐ N Anaphylaxis (severe allergic reaction)	☐ Y ☐ N Drug Addiction	☐ Y ☐ N Hepatitis B or C	☐ Y ☐ N Renal Dialysis
☐ Y ☐ N Anemia	☐ Y ☐ N Easily Winded (get tired very easily)	☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Angina (Chest Pains)
☐ Y ☐ N Emphysema	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Rheumatism	☐ Y ☐ N Arthritis or Gout
☐ Y ☐ N Epilepsy/Seizures	☐ Y ☐ N High Cholesterol	☐ Y ☐ N Scarlet Fever	☐ Y ☐ N Artificial Heart Valve
☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Hives or Rash	☐ Y ☐ N Shingles	☐ Y ☐ N Artificial Joints
☐ Y ☐ N Excessive Thirst	☐ Y ☐ N Hypo-Glycemia (Low sugar)	☐ Y ☐ N Sickle Cell Disease	☐ Y ☐ N Asthma
☐ Y ☐ N Fainting/Dizziness	☐ Y ☐ N Irregular Heartbeat	☐ Y ☐ N Sinus Trouble	☐ Y ☐ N Blood Disease
☐ Y ☐ N Frequent Cough	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Spina Bifida	☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Frequent Diarrhea	☐ Y ☐ N Leukemia	☐ Y ☐ N Stomach/Intestinal Disease	☐ Y ☐ N Breathing Problems
☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Liver Disease	☐ Y ☐ N Stroke	☐ Y ☐ N Bruise Easily
☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Swelling of Limbs	☐ Y ☐ N Cancer of any kind	☐ Y ☐ N Glaucoma
☐ Y ☐ N Lung Disease	☐ Y ☐ N Thyroid Disease	☐ Y ☐ N Chemotherapy	☐ Y ☐ N Hay Fever (seasonal allergies)
☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Tonsillitis	☐ Y ☐ N Heart Attack/Heart failure	☐ Y ☐ N Osteoporosis
☐ Y ☐ N Tuberculosis	☐ Y ☐ N Cold Sores/Fever Blisters	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Tumors or Growths	☐ Y ☐ N Congenital Heart Disorder	☐ Y ☐ N Heart Pacemaker	☐ Y ☐ N Parathyroid Disease
☐ Y ☐ N Ulcers	☐ Y ☐ N Psychiatric Care	☐ Y ☐ N Sexually Transmitted disease of any kind	☐ Y ☐ N Yellow Jaundice
☐ Y ☐ N Hyper-Glycemia (HIGH blood sugar)			

Have you had or do you have any other illness not listed above? ☐ Yes ☐ No If yes, please explain_____

Additional 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 Dr. Barniv and his staff of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

MODERN FAMILY DENTAL

PATIENTS WITH DENTAL INSURANCE

(You do not need to fill this form out unless you are using dental insurance)

1. Modern Family Dental will bill your insurance as a courtesy to you; however, the relationship remains between you and the insurance company. For questions or concerns about payments and plan terms, you will need to contact your insurance company directly.

2. Modern Family Dental will make every effort to get accurate information from your insurance company and will provide you with an estimate for your recommended treatment. Sometimes, insurance companies provide us with wrong information or don't fully disclose all the details of your plan. This may result in less than the expected payment. In some rare cases, the insurance company will make no payment at all.

3. It is important to understand that you are responsible for any fees not covered by your insurance plan, regardless of the original estimate you were given. The unpaid portion is due within **30 days**. A billing charge of 1.5% per month will be assessed for unpaid balances over 30 days.

Do you authorize Modern Family Dental to bill the insurance company on your behalf and to share with them x-rays, pictures and other documentation as necessary?_____
(Yes or No)

By writing your initials on the line below, you agree to take full responsibility for paying any unpaid insurance portion within 30 days, regardless of the original estimate.

_____Initial, if you agree

I understand and agree to the contents of this document. I also agree to pay a 1.5% monthly billing charge for any unpaid balance that is 30 days overdue.

Name (financially responsible person):_____ **Date:**_____

Signature:_____