

# PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  
IF COLLEGE STUDENT, F.T./P.T. NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SPOUSE OR PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ TEL # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY/ID# \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ TEL # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY/ID# \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT \_\_\_\_\_

X \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT GUARDIAN IF MINOR

\_\_\_\_\_  
PATIENT NUMBER

**REGISTRATION**

## Communication Consent

It is the office policy of Dr. Cuong B. Tran DMD, MAGD, FICOI and staff not to release confidential and/or unauthorized information, without consent, on home telephone, answering machine, work telephone, voice mail, cell phone, text message and email. Whenever returning telephone calls and the answering machine/ voice mail pick up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Dr. Cuong B. Tran DMD, MAGD, FICOI and his staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

<b>Home Telephone</b>		<b>Yes</b>	<b>No</b>
<b>Home Answering Machine</b>		<b>Yes</b>	<b>No</b>
<b>Work Telephone</b>		<b>Yes</b>	<b>No</b>
<b>Work Voice Mail</b>		<b>Yes</b>	<b>No</b>
<b>Cell Phone</b>		<b>Yes</b>	<b>No</b>
<b>Cell Voice Mail</b>		<b>Yes</b>	<b>No</b>
<b>Email</b>		<b>Yes</b>	<b>No</b>

If you would like to have information released to someone other than yourself please complete the following:

Please print the name and relationship of authorized person:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name Printed: \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_