FAIR CITY DENTAL CARE

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION/INFORMACION DEL PACIENTE

NAME/NOMBRE________________________________ DATE/FECHA______________
FIRST MI LAST

ADDRESS/DIRECCION____
CITY/CIUDAD

PHONE #/TELEFONO__________________ CELL ____________________ WORK/TRABAJO______________

AGE/EDAD___ BIRTHDATE/FECHA DE NACIMIENTO__________________ MARITAL STATUS/ESTADO CIVIL_________
MONTH DAY YEAR

SEX/SEXO_________ SOC.SEC. NUMBER/NUMERO DE SEGURO SOCIAL_________________________________

PRIMARY DENTAL INSURANCE/SEGURO DENTAL

NAME OF PRIMARY INS. HOLDER/NOMBRE DEL ASEGURADO______________________BIRTHDATE/FECHA DE NACIMIENTO__________________
MONTH DAY YEAR

NAME OF INSURANCE/NOMBRE DEL SEGURO _______________ SOC.SEC. NUMBER/NUMERO DE SEGURO SOCIAL______________________

GROUP NUMBER/NUMERO DE GRUPO______________ PHONE#/TELEFONO______________________

DENTAL HISTORY/HISTORIA DENTAL

*INFORMATION THAT YOU FEEL IS INSIGNIFICANT COULD BE DIRECTLY RELATED TO YOUR DENTAL HEALTH. ANSWERING THE FOLLOWING QUESTIONS WILL PROVIDE US WITH A THOROUGH UNDERSTANDING OF YOUR PHYSICAL CONDITION FOR PROPER RECOMMENDATIONS REGARDING YOUR DENTAL CARE. THIS INFORMATION IS STRICTLY CONFIDENTIAL. THANK YOU FOR COMPLETING ALL QUESTIONS IN DETAIL.

*INFORMACION QUE USTED CREE INSINGNIFICANTE PUEDE SER DIRECTAMENTE RELACIONADA CON SU SALUD DENTAL. CONTESTADO LAS SIGUIENTES PREGUNTAS NOS PROVEERA SUFICIENTE ENTENDIMIENTO DE SU CONDICION FISICA PARA APROPIADAMENTE HACER RECOMENDACIONES DENTALES. ESTA INFORMACION ES COMPLETAMENTE CONFIDENCIAL. GRACIAS POR COMPLETAR TODAS LAS PREGUNTAS EN DETALLE.

WHAT IS THE REASON FOR THIS APPOINTMENT? / CUAL ES LA RAZON DE ESTA CITA?_________________________________

ARE YOU UNDER THE CARE OF A PHYSICIAN? / ESTA USTED BAJO EL TRATAMENTO DE ALGUN MEDICO?_________________________

REASON/RAZON? ____

ARE YOU TAKING AY MEDICINE OR DRUGS? / ESTA USTED TOMANDO ALGUN MEDICAMENTO O DROGA?_____________________

LIST/ NOMBRELOS____

DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENS? ☐ YES ☐ NO NAME OF ANTIBIOTIC:__________

USTED NECESITA TOMAR ANTIBIOTICO ANTES SU CITA DENTAL ? ☐ YES ☐ NO NAME OF ANTIBIOTIC:___________________________

ARE YOU ALLERGIC TO ANYTHING? (DRUGS, FOOD) / ES USTED ALERGICO A ALGO? (MEDICINAS,COMIDAS)?_____________________

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING? / HA TENIDO O TIENE USTED ALGUNO DE LOS SIGUIENTES?

HEART TROUBLE? / PROBLEMAS DEL CORAZON?________	YES	NO
RHEUMATIC FEVER/FIEBRE REUMATICA________	YES	NO
DIABETES/DIABETIS________	YES	NO
HEART MURMUR/ SOPLO________	YES	NO
HIGH OR LOW BLOOD PRESSURE / PRESION ALTA O BAJA________	YES	NO
LIVER DISEASE(HEPATITIS) / PROBLEMAS DEL HIGADO (HEPATITIS)________	YES	NO
EPILEPSY (SEIZURES)/ EPILEPSIA________	YES	NO
CANCER/CANCER________	YES	NO
TUBERCULOSIS/TUBERCULOSIS________	YES	NO
ANEMIA/ANEMIA________	YES	NO
BLOOD DISEASE/ PROBLEMAS DE LA SANGRE________	YES	NO
ASTHMA/ASTHMA________	YES	NO
A.I.D.S / S.I.D.A________	YES	NO
DO YOU SMOKE? PACKS PER DAY? / USTED FUMA? CUANTOS PAQUETES?________	YES	NO
ARE YOU PREGNANT? / ESTA USTED EMBARAZADA?________	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DENTIST OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATION.
MEDIANTE MI FIRMA ACEPTO QUE HE COMPLETADO Y ENTENDIDO LO ESTABLECIDO Y LE INFORMARE AL DENTISTA DE CUALQUIER CAMBIO DE MI SALUD O MEDICINA.

PATIENTS SIGNATURE/FIRMA________________________________ DATE/FECHA____________________

Fair City Mall Dental Care

Financial Policy

We are pleased that many of you have dental benefits and our office will assist you in obtaining that maximum benefits specified in your contract. **HOWEVER**, your benefits are a contract between you, your employer, and carrier. We will assist you in determining your benefits as best as we can. Because plans differ from carriers to carrier and policy to policy, our office may refer you to your carrier or employer's benefits coordinator for assistance in understanding your plan. When a breakdown of benefits is given from your Insurance, The breakdown of benefits is **ONLY** an **ESTIMATED AMOUNT** of what they will cover.

As a courtesy to you, we will file your benefits claim and accept assignment of benefits. We ask that your **ESTIMATED** co-payment and deductible be paid at the time of service.

Balances with benefit claims outstanding more then 90 days may be reverted back to the patient.

NOT ALL SERVICES ARE COVERED benefit in all contracts. It is your Responsibility to know or find out what is covered or downgraded by your insurance. Some carriers and employers select only some services to be covered. You ARE responsible for payment of **ALL SERVICES** regardless of the payable benefit.

Our office participates with very few insurance companies. It is your responsibility to ask whether we are **IN NETWORK OR OUT OF NETWORK**. Many PPO Insurance Companies to Not Accept Assignment of Benefits and payment is mailed directly to you, In that case you ARE responsible for the treatment, and payment will need to be made at the time of service for your treatment.

ANY RETURNED CHECKS will have a **$30 charge to your account,** in addition to what you **OWE**. You will have to make payment with cash, money order, or credit card thereafter.

AGED ACCOUNTS

Balance older than 60 days may be subject to additional fees and interest of 1% per month, or 12% annually. These additional fees will be applied to the unpaid balance at the end of the second month. In the event that your account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs and collection agency fees).

I, as a patient, have read and understood the statements and terms listed above.

Patient Signature____________________ Date_______________

Póliza de Pago

Estamos felices que muchos de ustedes tienen seguro dental, nuestra oficina los assitirá en obtener el máximo beneficio specificado por su contrato de seguro. **Sin Embargo** los beneficios son bajo un contrato entre usted, su empleo y su seguro. Nosotros los vamos asistir en determinar sus beneficios lo mejor que podamos. Todos los planes de seguros son diferentes a otros planes de seguro y las pólizas de cada seguro son diferentes, tendremos que referir con su empleador y seguro o cordinador de beneficios para pedir assitencia en poder entender su plan. Cuando su seguro nos de un resumen de sus beneficios, ese resumen es **SOLO UN ESTIMADO** de lo que pagarán.

Como cortesía nosotros mandaremos todas las formas necesarias para recibir el pago de su seguro y aceptaremos que ellos nos paguen directamente. Les pedimos que el **ESTIMADO co-PAGO y Reducible sean págado el dia de su cita**.

Balances de 90 dias o mas que su seguro no pagó sera su RESPONSABILIDAD y tendrá que pagar su balance. **NO TODOS** los servicios son pagados por el seguro. **ES** su responsabilidad mantenerse informado que es lo que cubre su seguro y que no cubre. **USTED SI ES RESPONSABLE POR TODOS LOS SERVICIOS PAGUE ó NO SU SEGURO.**

Nuestra oficina participa con pocos seguros dentales. **ES** su responsabilidad de pregutar si **estamos participando con su seguro**. Muchos seguros no aceptaran mandar el pago directamente al dentista si no que se lo manda directamente a usted. En esos casos Usted es responsable de pagar por su tratamiento el dia de su servicio.

La oficina le cobrara $30 por cada Cheque sin fondo mas lo que debe. Tendra que hacer un pago con efectivo,money order, o tarjeta de credito.

CUENTAS DELINQUENTES

Balances de mas de 60 dias se les agregara el 1% de interes por mes o 12% annual. Estos cargos seran aplicados a sus balances al final del Segundo mes. En el evento que su cuenta no es pagada y tenemos que referir su cuenta a colección usted sera responsable por todos lo gastos por ejemplo costo de abogados, costo de corte y el costo de la agencia de colección.

Mediante mi firma acepto haber leído y entendido lo establecido anteriormente.

Firma_______________________ Fecha____________________

Assignment of Benefits

I hereby authorize and direct payment of dental benefits otherwise payable to me for all of my dental claims, directly to:
Yo autorizo que todos los pagos de mi seguro sean directamente pagados a:

Travis Le, DDS, PC
Allie Tran, DDS, PC
Selina H Tran, DMD, PC
Fair City Dental Care
9600-I Main St.
Fairfax, VA 22031
TIN:47-0939988

Signature/Firma:_______________________

Date of Birth/ Dia de Nacimiento:__________________

Fair City Mall Dental Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Purpose: This Notice of Privacy Practices presents the information that the HIPAA Privacy Rules require us to give our patients regarding our privacy practices.

We must provide this Notice to each patient no later than the date of our first service delivery to the patient, after April 14, 2003. We must also have the Notice available to the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service form us to be able to read the Notice. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. There after, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices for time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

Office Use Only

I have attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

Date	Authorized Personnel	Reason

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE