MANGROVE BAY DENTISTRY
Family & Cosmetic Dental Care

New Patient Registration

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help.

Whom may we thank for referring you?* _____

Chief Complaint/ Reason for visit:* _____

Last Dental Visit Was* ___ / ___ / ___

Name and Number of Previous Dental Office:*
Name: _____ Number: _____

About You

Patient Name: _____ _____ I prefer to be called _____
First Last

☐ Female ☐ Male ☐ Single ☐ Married ☐ Child ☐ Other

Birth date: ___ / ___ / ___ Age: _____

Cell _____ Home _____ Email _____

Home Address

_____ _____
Street Address City

_____ _____
State Zip Code

S.S. #: _____ Employer _____ How long there? _____

Work: _____ Occupation: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name: _____ _____ Birth date: ___ / ___ / ___
First Last

Relation: _____ S.S. #: _____ Home phone: _____

☐ Same as above

Home Address

_____ _____

Street Address City

_____ _____

State Zip Code

Employer _____ How long there? _____

Work: _____ Occupation: _____

SPOUSE / EMERGENCY CONTACT

Name: _____ _____ Relation: _____

First Last

Birth date: ___ /___ / ___ Phone: _____

Home Address

_____ _____

Street Address City

_____ _____

State Zip Code

Employer _____ Work Phone: _____

DENTAL BENEFIT INFORMATION

Primary Insurance

Insurance Company Name: _____ Phone: _____

Policy # and Group #: _____ Insured's Employer: _____

Insured's Name: _____ _____ Insured's Birth date: ___ / ___ / ___

First Last

Relation: _____ Insured's S.S. #: _____

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Medical History

We also request that you fill out the Medical History Update form below before your appointment. Health problems that you may have, or medications that you may be taking, could have an important impact on your recommended dental care.

Patient Name: _____ _____ Email _____
First Last

Are you under a physician's care now?
☐ Yes ☐ No If yes:

Have you ever been hospitalized or had a major operation?
☐ Yes ☐ No If yes:

Have you ever had a serious head/ neck injury?
☐ Yes ☐ No If yes:

Are you taking any medications, pills, or drugs?
☐ Yes ☐ No Please list here:

Have you ever taken Bisphosphonates (Prolia, Fosomax, Actonel, Zometa, Aredia, Boniva, Reclast)?
☐ Yes ☐ No If yes:

Have you ever been diagnosed with Osteoporosis/Osteonecrosis?
☐ Yes ☐ No If yes:

Do you use tobacco?
☐ Yes ☐ No

WOMEN: Are you....

☐ Pregnant/ Trying to get pregnant? ☐ Nursing/ Breast feeding? ☐ Taking oral contraceptives?

Have you informed your OB/GYN of your dental appointment?
☐ Yes ☐ No

Name of OB/GYN _____ Phone Number of OB/GYN _____

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metal
- ☐ Sulfa Drugs
- ☐ Amoxicillin/Penicillin
- ☐ Local Anesthetics
- ☐ Other

Do you use controlled substances?

☐ Yes ☐ No If yes:

Do you have any of the following?

- ☐ Acid Reflux
- ☐ Allergies/Hay fever
- ☐ Alzheimers Disease
- ☐ Anaphylaxis Reaction
- ☐ Anemia
- ☐ Angina/Chest Pains
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Erectile Dysfunction
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Disease (Congenital)
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS Positive
- ☐ Hives/Rash
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle cell Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Stomach/Intestinal Problems
- ☐ Stroke
- ☐ Surgical Stent
- ☐ Thyroid Disorder
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease/STD
- ☐ Yellow Jaundice

Do you have any health problems/ conditions that were not listed above or need further clarification?

☐ Yes ☐No If yes:

Patient Signature _____ Date: ___ / ___ /___

Doctor Signature _____ Date: ___ / ___ /___

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Financial Policy

Unless another financial option is PRE-ARRANGED, payment is due in full the day of treatment, or on pre-op visits for extensive treatment appointments. Should a patient have dental insurance with assignment to Dr. Tran, the estimated patient portion will be the amount due. Any discrepancies with insurance eligibility and/or benefits will be the patient's responsibility to pay the balance. Insurance payments without assignment will be sent to the insured with payment due in full. The insurance plan is YOURS, as a courtesy, our office will help file any insurance claims. Hence, it is your responsibility to inform us of any changes prior to your dental visits. Our office has no leverage for payments; you are ultimately responsible for all payments when service is rendered. In addition, we have a 48 hours cancellation policy. We reserve the right to charge for any broken, no show and cancelled appointments without a minimum notice of 48 hrs.

Payment Options

1. For your convenience we accept Cash, Visa, MasterCard, American Express, Discover, & Check.
2. We also offer short and long-term financing options. (Interest-free options may apply- Care Credit)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor, is the responsible party for all dental services provided. Dental insurance in most cases is only a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you, as best we can, during your appointment. We will wait up to 60 (sixty) days for the insurance payment to be received and applied to your account. After the 60 days is up, the responsible party is responsible for the balance unpaid. The responsible party for the account must pay any deductible, co-payments, non-covered services, or difference between the insurance company fees and the office fees at the time services are completed. It is your responsibility to notify the office staff if there are any changes in your insurance coverage. Please ask us if you have any questions.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- Failure to make a payment for more than 90 days may result in the patient account being turned over to a collection agency. Patient and/or legal guardian will be responsible for any collection fees involved.
- Returned checks are subject to a minimum of $40 accounting fee.

CANCELLATION AND BROKEN APPOINTMENT POLICY

We consider the time set aside for your appointment to be your reserved time. Consequently, when you do not provide us with a 48 hour courtesy call or email, our other patients waiting for an open appointment are affected. In order to allow all of our patients to experience the best available arrangements, please be aware of our Cancellation and No Show Policies and associated fees.

Please remember that you are a valuable member of our dental practice. This policy is constructed to better serve all of our patients, and we thank you for your cooperation.

Please cancel within normal business hours with at least 48 hours notice: Cancellations are only recognized when called or emailed during normal business hours. Please be certain that you have cancelled at least 48 hours prior to your appointment. One of our team members will gladly speak with you regarding scheduling, as **we do not accept cancellations through our answering system.**

Emergencies: We understand that true emergencies do arise. Appointments missed by an individual due to reasons beyond his/her control will be taken under careful consideration.

I have read this policy and asked any questions I may have. I understand that, if I do not cancel within the 48 hour notice period, I will be subject to a cancellation fee.

Patient Name _____

Patient Signature _____ Date: ____ / ____ / ____

Mangrove Bay Dentistry
Family & Cosmetic Dental Care

Authorization and Consent

General Consent to Treatment

I agree and consent to a dental examination and x-rays by Dr. Toan Tran and his associates. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Toan Tran to release any information regarding my dental/medical history, diagnosis and/or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Toan Tran, Mangrove Bay Dentistry P.A.

Photography Release

I authorize Dr. Toan Tran and/or his associates to take intra-oral and extra-oral photographs of me to help me better understand my current dental condition and possible treatment options.
I authorize Dr. Toan Tran to show dental photographs and x-rays, excluding self-portraits, to other patients to better explain their treatment options with the understanding that personal information (ie: name) will NOT be disclosed.

I understand and will comply with office **Appointment Policy.**
I understand and will comply with the office **Financial Policy.**
I understand and agree to the **General Consent to Treatment.**
I authorize the **Release of Information/HIPPA.**

HIPAA RELEASE OF INFORMATION

☐ I authorize the release of information including scheduling, appointment reminders, diagnosis, treatment, and records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____
☐ Child(ren) _____
☐ Other _____
☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ My Home ☐ My Work ☐ My Cell

The best time to reach me is (day) _____ between (time) _____

May we text you regarding your appointment? ☐ Yes ☐ No
May we email you regarding your appointment? ☐ Yes ☐ No

If unable to reach me:
☐ **You may leave a detailed message**
☐ **Please leave a message asking me to return your call**
☐ _____

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have read/received a copy of this practice's Notice of Privacy Practices (HIPAA).
I understand that I may ask any questions I might have regarding this notice.

Patient and/or Legal Guardian Signature _____ Date: ___ / ___ / ___