

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? another patient, friend another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Sara T. Truong, D.D.S., I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand ALL BOUNCED CHECKS WILL BE CHARGED UP TO TWO TIMES THE CHECK AMOUNT. I also understand if my account is forced to be sent to collections for non payment, I will be charged up to two times the amount of my balance.

I grant my permission to Sara T. Truong, D.D.S. or her assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian and guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Help us get to know you

When I think about coming to the dentist I feel

- comfortable
- anxious
- fearful
- extremely fearful

I have avoided the dentist because of

- my anxiety and fear
- past experiences
- cost
- no time
- lack of trust
- other _____

My childhood dental experiences were

- completely pain free and comfortable
- somewhat uncomfortable
- painful
- traumatic
- I did not go to the dentist as a child

My dental experiences as an adult have been

- completely pain free and comfortable
- somewhat uncomfortable
- painful
- traumatic
- I have not seen the dentist as an adult or my visits have been very few

I have fear of-I have concerns about

- experiencing pain
- not being numb
- needles
- unnecessary or wrong treatment
- gagging
- losing control
- having something put over my mouth
- being scolded or made to feel ashamed
- catching a disease
- losing my teeth
- having to wear a denture or partial
- other _____

The following makes me uncomfortable

- the sounds of a dental drill
- laying down in a dental chair
- the smells in a dental office
- being numb
- having to wait in the reception area
- other _____

To understand what's going on in my mouth, my preference is

- to know all the details
- to be given the bottom line
- to be shown pictures and movies
- to read pamphlets and brochures
- to talk with a team member about solutions to my problems

My immediate concern about my teeth and smile is
