PATIENT REGISTRATION

Name of Patient _____

Mailing Address _____

City _____Zip Code _____

Home / Cell Telephone # _____ Date of Birth _____

Work / Other Telephone # _____ Social Security # _____

Email _____

Reason for Visit _____

Name of person who subscribes to the insurance/If a Medicaid program, parent information is Needed here

_____

Subscribers Mailing Address if different from above_____

City_____ Zip Code _____

Home / Cell Telephone # _____ Date of Birth _____

Work / Other Telephone # _____ Social Security # _____

Where Employed _____

Work Address _____ Zip Code _____

Name of Insurance Company _____

Mailing Address _____

City _____Zip Code _____

Insurance Telephone # _____

Subscriber Identification/Policy # _____Group # _____

*Patient share of payment is due at the time of service. We do not accept checks. A fee of $30.00 will be charged for appointments that were not cancelled within 24 hours in advance. I understand that a 1.5% interest rate will be added to delinquent accounts and that I am responsible for my account balance and any additional Attorney or Collection Agency fees.

Signature _____ Date _____

MEDICAL HISTORY

Check yes or no if you have or have had the following:

1. Diabetes _____ yes _____ no
2. Anemia _____ yes _____ no
3. Hepatitis _____ yes _____ no (if yes, when? _____)
4. Rheumatic Fever _____ yes _____ no
5. Heart Disease _____ yes _____ no
6. High Blood Pressure _____ yes _____ no
7. Abnormal Bleeding _____ yes _____ no
8. Tuberculosis _____ yes _____ no
9. Other _____
10. What medications do you take: _____

_____

11. Are you under a Doctor's care at the present time? _____ yes _____ no

If yes, for what purpose? _____

12. HIV positive: _____ yes _____ no

13. How much do you smoke? (number of cigarettes, cigars, pipe per day): _____

14. Any chronic or long standing diseases or treatment not noted above?

    a. Cancer _____ yes _____no
    b. Depression _____ yes _____no
    c. Liver, Kidney, Bladder, Colon, Lung, etc. _____ yes _____no
       (if yes, circle one)

15. What drug allergies do you have: _____

16. Are you pregnant? _____ yes _____no
    If YES what is the estimated due date? _____

Initials _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from 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 from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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 requested 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 attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Dr. Lynn Vu D.D.S., PC
17865 Main Street
Dumfries, VA. 22026
Office: 703-221-7000 Fax: 703-441-1746

Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. As part of our services, we try to contain the ever-rising cost of health care. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICES RENDERED.
WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, OR DEBIT CARDS

Regarding Insurance:
Dental insurance is a contract between you, your employer, and the insurance company. The extent of your coverage varies from company to company, and from plan to plan. **You are responsible for payment regardless of the insurance company's determination of usual and customary rates/fees.**

We will make every effort to assist you with your particular coverage. As a courtesy to our patients, we will prepare and submit your insurance claim. If your insurance has not been verified prior to your appointment, you may be required to pay in full.

If you have coverage with more than one company, we will prepare billing for one company. We will however, provide you with the necessary paperwork that you may submit to the secondary.

We will provide you with an estimate prior to treatment that will show anticipated insurance payment to us and the estimated patient share of every procedure. Patient share, including deductible will be due at the time of treatment. If our estimate results in overpayment from the insurance company, your account will be credited. If the insurance did not pay their expected portion of the estimate, the balance will be transferred to the patient.

MINOR PATIENTS:
The adult accompanying a minor is responsible for any patient share due at the time of treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

** _____ ** _____
Signature of Patient or Responsible Party Date