Patient Registration

Linh T. Tran, DDS, PC

Name _____ Date _____
Last First Middle

[ ]Male [ ]Female Age _____
[ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated

SS# _____ Birthdate ____-____-____
Home address _____ Employer _____
_____ Occupation _____
Home phone # _____ Work Phone # _____
Cell phone # _____ Email address _____

Who referred you to this office? _____
Previous/Present Dentist _____

SPOUSE NAME _____ Work Phone # _____
Spouse's Employer: _____ Occupation _____

IN THE EVENT OF AN EMERGENCY, whom should we contact? _____
Relation _____ Home/Work Phone # _____

PERSON RESPONSIBLE FOR ACCOUNT: _____
Relation _____ Birthdate ____-____-____
SS# _____ Home Phone # _____
Occupation _____ Employer _____
Billing Address _____

PRIMARY DENTAL INSURANCE CO. NAME: _____
Insured's Name _____ Relation _____
Insured's Birthday _____ SS# _____
Insured's Employer _____ Work Phone # _____

ASSIGNMENT & RELEASE: I, the undersigned, assign directly to Dr. Linh T. Tran, DDS, PC, all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether financial or electronic. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parent/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for any charges not covered by insurance.

_____ _____
Patient Signature (Parent/Guardian if a minor) Date