Welcome to the Office of Dr. Maryam Hoang

NAME	DATE OF BIRTH	SOCIAL SECURITY #

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	E-MAIL

EMPLOYER	EMPLOYER ADDRESS

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE

PRIMARY INSURANCE COMPANY	ADDRESS	PHONE

SUBSCRIBER	DATE OF BIRTH	GROUP #	SOCIAL SECURITY #

EMPLOYER NAME AND ADDRESS	RELATIONSHIP TO PATIENT	GRADE IF STUDENT

SECONDARY INSURANCE COMPANY	ADDRESS	PHONE

SUBSCRIBER	DATE OF BIRTH	GROUP #	SOCIAL SECURITY #

EMPLOYER NAME AND ADDRESS	RELATIONSHIP TO PATIENT	GRADE IF STUDENT

FAMILY INFORMATION

NEXT OF KIN	RELATIONSHIP	IN CASE OF EMERGENCY NOTIFY

ADDRESS IF DIFFERENT FROM PATIENT'S	ADDRESS IF DIFFERENT FROM PATIENT'S

HOME PHONE	WORK PHONE	EXT	HOME PHONE	WORK PHONE	EXT

EMPLOYER	**PERSON RESPONSIBLE FOR ACCOUNT**
	ADDRESS IF DIFFERENT FROM PATIENT'S

AUTHORIZATION

The undersigned authorizes payment from my dental insurance carrier to be paid directly to Dr. Maryam Hoang for dental treatment benefits otherwise payable to me. **I understand that I am responsible for all costs of such dental treatment received regardless of insurance status**. I hereby authorize Dr Maryam Hoang to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this form and the dental/medical histories are correct to the best of my knowledge. I also authorize Dr. Maryam Hoang to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Responsible Party Date Relationship to Patient

METHOD OF PAYMENT

All charges you incur are your responsibility regardless of your insurance coverage. As a courtesy to you we will help you process your insurance claims. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full. Uninsured patients will be asked to pay in full for services rendered on the day they are received. Insured patients will be asked to pay a co-payment according to their benefit schedule on the day services are rendered. Our office accepts many forms of payments. We accept cash, MasterCard, Visa, American Express, Discover, Visa Check Cards, and special no interest financing programs available through Care Credit.

FINANCIAL AGREEMENT

I agree to pay for services as they are rendered. If covered by dental insurance, I agree to pay any balance on my account after my insurance has paid their portion of the dental services rendered to me within 25 days of the monthly billing date. I understand that any legal interest on the unpaid balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be my responsibility.

Responsible Party Date Relationship to Patient

APPOINTMENTS

We ask that our patients give us at least 24 hours notice if they cannot keep their appointments. There will be a $50.00 missed appointment fee charged for appointments that are not kept.

I agree to keep all my scheduled appointments at Sierra Sunrise Dental. If an appointment is missed without notice, I agree to pay a fee of $50.00. Signed____