Care Dental Spa

www.caredentalspa.com info@caredentalspa.com
Dr. Quang Luong | 5297 South 31st Street Ste 111 • Temple, TX 76502 (254)773-0055

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First ___ MI _____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext _____ Fax _____ Other

Address: _____ Address 1 _____ Address 2

_____ City _____ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name, Relation and Phone number below: *

_____

_____

Primary Dental Insurance:

Name of Insured: _____ Last _____ First ___ MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ Address 1 _____ Address 2

_____ City _____ State _____-____ Zip Code

Insured's Employer Name: _____

Employer Address: _____ Address 1 _____ Address 2

_____ City _____ State _____-____ Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ Address 1 _____ Address 2

_____ City _____ State _____-____ Zip Code

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial responsibility on the part of each patient must be determined before treatment.

For patients who are fortunate enough to have dental insurance, we help you maximize the benefits provided by your insurance and also file your insurance forms which will save you considerable time and trouble. Your dental insurance is intended to help cover a certain portion of the cost, this portion will be dependent on the plan.
Please remember, however, that the financial obligation for dental treatment is between you and this office and is not between us and the insurance company.

I agree to pay the charges for the services at the time of treatment. If payment is not received after 30 days, your account will be sent to an outside collection agency where an additional $250.00 collection fee will be added.

I understand that there will be a "No-Show" fee of $45.00 if a patient does not give notice prior to 24 business hours.

There is also a $30.00 fee on all returned checks.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I consent to having any photos of me and/or my teeth to be used for social media purposes.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____