HA TO JACKLYNN THAI, D.D.S.
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24700 CALAROGA AVE., SUITE 104
HAYWARD, CA. 94545
PHONE: 510-785-9295
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PATIENT REGISTRATION

Date: _____

Patient's Last Name: _____ First Name: _____ Male: ____ Female: ____

Patient's D.O.B: _____ Age: _____ Patient's S.S#: _____

Address: _____ City: _____ Sate: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Emerg. Contact: _____ Phone: _____ Relationship to Patient: _____

E-mail Address: _____

How did you hear of us? Online: _____ Yellow Pages: _____ Friend: _____ Other: _____

PARENT INFORMATION

Mother's Name: _____ D.O.B: _____ S.S# _____

Employer: _____ Employer Phone Number: _____

Father's Name: _____ D.O.B: _____ S.S# _____

Employer: _____ Employer Phone Number: _____

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ D.O.B: _____ I.D. #: _____

Insurance Name: _____ Insurance Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group I.D #: _____

SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ D.O.B: _____ I.D. #: _____

Insurance Name: _____ Insurance Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group I.D #: _____

OVER

TERMS AND CONDITIONS

PAYMENT FOR DENTAL SERVICES: Insurance policies are contracts between you and the insurance company. This dental office will help prepare the patient's insurance forms and submit claims on our patient's behalf to assist in making collection from the insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company and if no payment is made, any balance is the responsibility of the patient (or guardian).

BROKEN APPOINTMENTS: A failed appointment fee of $45.00 per failed appointment may be charged for all appointments that are broken without a 48 hour cancellation notice. I agree to pay this fee if I fail to properly notify the office in the event of a cancellation. I am also aware that I must be on time for any scheduled appointments or the office has the option to reschedule my appointment.

WHAT WE DO:

- Provide you with and **ESTIMATE** of treatment and patient portions
- Prepare and mail the insurance claim form(s) on your behalf
- Send you an itemized statement each month of charges accrued &/or balances on your account

WHAT WE EXPECT OF YOU:

- Provide complete and accurate information
- Advise us of any changes to coverage or other patient information
- Pay your estimated patient portion at the time of each appointment
- Contact your insurance or employer if payment is not received within 60 days of treatment
- Forward to us insurance checks that are sent to you if you have a balance

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I have read the above "TERMS AND CONDITIONS" and hereby fully agree to their content. I hereby authorize the office of, **HA T. THAI, D.D.S., Inc.** and associates to render professional dental services on my child.

_____

Signature of parent or guardian Date

_____

Print Name Relationship to patient