Menlo Park Dental Excellence/ChauLong T. Nguyen Dental Corporation

ChauLong Nguyen, DDS, MAGD, LLSR, AF AAID

905 Middlefield Road, Ste B, Palo Alto, CA 94301 (650) 838-0260

PATIENT INFORMATION

Name: _____ **Home Phone: _____**

Address: _____ **Office Phone: _____**

City: _____ **Cell Phone: _____**

State & Zip: _____ **E-mail address: _____**

Date of Birth: _____ **Marital Status: _____**

Gender: _____ **Social Security: _____**

The law requires that all prescriptions in California shall be issued as an electronic data transmission prescription (e-prescriptions).

Pharmacy Name: _____

Address: _____ **Phone #: _____**

Person responsible for account: ▢ Self or ▢ Other:_____

IF PATIENT IS A CHILD/MINOR
Name of Parent or Guardian: _____
Phone #: _____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

Primary Insurance	*Secondary Insurance*
Name of Insured: _____	**Name of Insured: _____**
Employer: _____	**Employer: _____**
Social Security #: _____	**Social Security #: _____**
Date of Birth: _____	**Date of Birth: _____**
Insurance Co. Name: _____	**Insurance Co. Name: _____**
Member ID:_____	**Member ID: _____**
Group or Plan #: _____	**Group or Plan#: _____**
Signature: _____	**Date: _____**

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FINANCIAL POLICY

NOTE: We Accept All PPO insurances. ***We are in network with Delta Dental Premier PPO only.***
All other out-of-network PPO insurance plans will require a co-payment at the time of service.

Patients WITH Dental Insurance

- Patients should understand that services are rendered and charged to you and not to the dental insurance company. We are happy to send claims to your insurance company for you; however, we suggest that you call your dental insurance company to confirm your eligibility, what services are covered and at what percentage that they will be covered for and how much your calendar or fiscal yearly maximum is.

For X-Rays, routine examination and cleaning appointments we request ful payment at time of provided care.

Emergency Detailed Tooth Pain Focus Exam cost $350 for Delta Premier & out of network insurances.
Delta Dental Premier patients are required to pay $245 for numbing inflamed bleeding painful gum.

- It is your responsibility to provide us with your correct insurance billing information if you choose to have us bill claims to your insurance company for you. This information includes your insurance company's name, address and contact information, the subscriber's employer if covered through a workplace policy, the identification number, and policy or group number that the insurance carrier uses to identify you. If we cannot verify your eligibility, then you will be responsible for the full cost of the services at the time they are rendered. Provide and update with us if your insurance has Calendar or Fiscal effective coverage dates.
- We are happy to provide you with a proposed treatment plan with estimated fees.
- Proposed treatment plans can be pre-authorized by your insurance company for you to determine your co-payment. These pre-authorizations take approximately 15 business days to be completed. Please be aware that the proposed plan may change at the time of treatment. You are required to pay the predetermined co-payment amount at the time of treatment.
- If you choose to go ahead with treatment before the pre-authorization is completed and received, you may be required to pay the amount of the treatment in full at the time the services are rendered. We will be happy to provide you with a claim that you may then submit to your insurance company and they can reimburse you directly for the costs of treatment.

Patients WITHOUT Dental Insurance

Payment in full is required at the time services are rendered. If you decide you cannot afford the treatment plan that is proposed, we are happy to refer you to Dental Schools/ other providers for your dental care. We will send all the necessary documentation and x-rays to your email so that you can forward your records to your future dentists.

We accept cash, checks - with a valid ID, major credit and debit cards.

Appointment time is reserved specifically for you. Please give us a minimum of 24-hour notice for cancellations or rescheduling. Less than 24-hour notice may result in a $50.00 cancellation charge.

By signing, you acknowledge and accept our financial policy as well as understanding your financial responsibility towards your dental care services.

Signature: _____ **Date**: _____