BAY ENDODONTICS
Root Canal Specialists

2844 Summit Street, Suite 209
Oakland, CA 94609
Phone: (510) 451-3636
Email: info@bayrootcanal.com

Phuong N. Quang, D.D.S., Ph.D.
Yvonne Chiu, D.D.S., M.S.

REGISTRATION

Date: _____

Patient Name: _____ Salutation (circle): Ms / Mrs / Mr / Dr

Phone: *Cell* _____ *Home* _____ *Work* _____

E-mail address: _____

Social Security #: _____ **Date of Birth** _____

Gender: ☐Male ☐ Female Age: _____

Home address: _____ Apt. _____

City, State _____ Zip _____

Occupation: _____ Employer: _____

Work address: _____ City, State _____ Zip _____

What is your preferred method of contact? ☐*Cell phone* ☐*Home phone* ☐*Work phone* ☐*E-mail*

Dental Insurance Information

Primary Dental Plan Name _____ Phone _____

Who is the primary subscriber? _____

Social Security or ID # _____ Date of Birth _____

Secondary Dental Plan Name _____ *Phone* _____

Name of Insured _____ *Relationship to Patient* _____

Social Security or ID # _____

Emergency Contact

Emergency contact name: _____

Relationship to Patient: _____ Phone: _____

Name of General Dentist: _____ Referring Dentist _____

Name of your Medical Doctor: _____ Medical/Kaiser # _____

Phone: _____ City _____ State _____ Zip _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Cash, Check, Credit Card.

Dental Insurance Plans: Your dental benefit is a contract between you and your employer and the dental insurance plan. Benefits and payments received are based on the terms of the contract negotiated between you and your employer and the plan. We are happy to help you understand and maximize your insurance coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental insurance plan) in full at the time of service. If your plan reimburses us less than the amount estimated, you are responsible for paying the balance in full upon receipt of a statement from our office. Any balances not paid in full in one month are subject to late payment penalty and interest charges (up to 15%).

If we are not a contracted provider with your plan, it is the patient's responsibility to verify with the plan whether they allow patients to receive reimbursement for services from out-of-network providers. If yes, we can file the claim on your behalf and receive reimbursement directly from the plan once you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan, even if that amount is different from our estimate. If you choose to not "assign benefits" to our practice, you are responsible for filing the claims and obtaining reimbursement directly from your dental insurance plan and will be responsible for payment in full to our practice at the time of service.

Scheduling of Appointments: To maintain the utmost service and care, we require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we need to reschedule an appointment if a patient is more than fifteen minutes late arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50.00 or deposit to reserve the appointment time again, may be required.

Authorization:

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ **(initial)**

I have read the above and agree to the financial and scheduling terms. _____**(initial)**

I authorize the release of my information necessary to process my dental insurance claims. I hereby authorize payment directly to this doctor otherwise payable to me. **YES / NO (circle one)** _____**(initial)**

I hereby acknowledge that a copy this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____**(initial)**

Signature_____**Date**_____