VINH T. PHAM, D.D.S.
75 S. San Tomas Aquino Rd., Ste.#2, Campbell, CA 95008 (408) 378-8500

NEW PATIENT REGISTRATION

Welcome! Your confidential answers to the following questions will help to establish you as a patient of record at this office.

Patient Name _____ Date of Birth _____ Sex _____

Home Address _____ Home Phone _____
Street City Zip

SS# _____ If Full Time Student, Name of School _____

Employer _____ Occupation _____ Business Phone _____

Marital Status _____ Spouse Name _____

Person responsible for this account (if other than above) _____

Address _____ Phone _____
Street City Zip

In case of emergency, please contact _____
Name Relationship Phone

FAMILY AND FRIENDS

Whom may we thank for referring you? _____

Have we treated other family members? Yes ☐ No ☐ Name(s) _____

Nearest relative not living with you _____ Relationship_____

Home address _____ Phone _____
Street City Zip

SPOUSE

Last Name _____ First Name & Initial _____

SS# _____ Date of Birth _____ Age _____

Employer _____ Occupation _____ How long? _____

Business Address _____ Business Phone _____

DENTAL INSURANCE

Insurance Information
Self (or parent)

Name _____
(First) (Last)

SS# _____

Date of Birth _____

Employed By _____

Business Address _____

Business Phone _____

Insurance Co. _____

Ins. Co. Address _____

Group No. _____ Local _____
Coverage is for ☐ Self ☐ Spouse ☐ Children
☐ Other(s) _____

Insurance Information
Spouse (or parent)

Name _____
(First) (Last)

SS# _____

Date of Birth _____

Employed By _____

Business Address _____

Business Phone _____

Insurance Co. _____

Ins. Co. Address _____

Group No. _____ Local _____
Coverage is for ☐ Self ☐ Spouse ☐ Children
☐ Other(s) _____

OFFICE POLICY INFORMATION All accounts are carried on a 30 day basis.
A 1½ % monthly billing charge will be assessed on all accounts regardless of insurance coverage at the 60 day cycle.
All patients are financially responsible for their account. The insurance company is responsible to the patient.
48 hours notice is required on all changes in appointments. Any notice less than this will result in a significant missed appointment fee.
Payment for New Patient and Emergency visits is required at the time of service.
Parents or guardians of minor children must accompany the child or submit written treatment and financial consent.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES WHETHER OR NOT PAID BY SAID INSURANCE. I AUTHORIZED SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT, AND HEREBY AUTHORIZED PAYMENT DIRECTLY TO VINH T. PHAM, D.D.S.
I HEREBY CERTIFY THAT I HAVE READ THE ABOVE POLICIES AND AGREE TO THE SAME.

Signed _____ **Date** _____
(responsible party if patient is a minor)