

Manteca Dental Care

Thank You For Selecting Our Dental Team! Please fill out this form completely. ¡Bienvenido a nuestra oficina! Favor de llenar esta form a completamente.

Patient's Information (Confidential)/Información del Paciente (Confidencial)

Name/Nombre: _____
Last/Apellido First/Nombre Middle/Inicial Preferred/Preferido

Date/Fecha: _____ M F _____ - _____ - _____
SS# | No. de Seguro Social Birthdate/Fecha de Nacimiento

Married/Casado(a) Single/Soltero(a) Child/Niño(a) Divorced/Divorciado(a) Other/Otro _____

Address/Dirección: _____
Street/Calle City/Ciudad Zip/Código Postal

Employer/Empleador: _____ Occupation/Ocupación: _____

School/Escuela: _____
Name/Nombre City/Ciudad Full-Time Part-Time

Contact Information/Información del Contacto

Home/Casa: _____ Work/Trabajo: _____ Cellular: _____

E-mail/Correo electrónico: _____

In case of an emergency, please contact/Contacto en caso de emergencia:

Name/Nombre: _____ Number/Teléfono _____

Whom May We Thank For Referring You?/¿A Quién Le Podemos Agradecer Por Referirlo?

- Name of/Nombre Del: Friend/Amigo(a) or Relative/Parienta: _____
 Yellow Pages/Phone Book (please circle): Valley Verizon YellowBook Hispanic Newspaper School
 Work Google Our Website Walk-in Newsletters Other/Otro _____

Responsible Party/Guarantor Information/Persona Responsable de la Cuenta

I understand that the person named as the "responsible party/guarantor" is financially responsible for total payment of any services, treatment, referral, or cancellation fees incurred by the patient named on this form, regardless if insurance remits payment or not (if applicable). Should there be a change in guarantor name(s), written notice must be provided to our office. Otherwise, the guarantor will remain the same until further notice. Initial here: _____

Responsible Party Name/Nombre de la Persona Responsable de la Cuenta _____

By signing below, I certify that the information entered is true and correct. Al firmar abajo, he respondido completamente y correctamente todas las preguntas.

Patient/Parent's Signature · Firma del Paciente/Padre: _____ Date: _____

Guarantor's Signature · Firma del Persona Responsable: _____ Date: _____

Manteca Dental Care

Please fill out the information about the person who has the insurance policy.
Complete la información de la persona que tiene la aseguranza.

Primary Insurance/Seguro Primario

Name/Nombre: _____
Last/Apellido First/Nombre Middle/Inicial Birthdate/Fecha de Nacimiento

Address/Dirección: _____
Street/Calle City/Ciudad Zip/Código Postal

Employer Name | Nombre De Empleador SS# | No. de Seguro Social Telephone/Telefono

Name of insurance plan/Nombre de Seguro _____
Group# | No. de Grupo

Relation to Patient/Relación al paciente: Self/Mísmo Spouse/Esposo(a) Child/Niño(a) Other/Otro

Secondary Insurance/Seguro Secundario

Name/Nombre: _____
Last/Apellido First/Nombre Middle/Inicial Birthdate/Fecha de Nacimiento

Address/Dirección: _____
Street/Calle City/Ciudad Zip/Código Postal

Employer Name | Nombre De Empleador SS# | No. de Seguro Social Telephone/Telefono

Name of insurance plan/Nombre de Seguro _____
Group# | No. de Grupo

Relation to Patient/Relación al paciente: Self/Mísmo Spouse/Esposo(a) Child/Niño(a) Other/Otro

Assignment of Benefits and Release for Payment

I certify that I, and/or my dependent(s)/spouse, have insurance coverage with the above insurance company and assign directly to Dr. Rick Van Tran, DDS DBA Manteca Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Rick Van Tran may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I acknowledge that the information entered is true and correct to the best of my knowledge. I agree to its content. Que yo sepa, he respondido completamente y correctamente todas las preguntas.

Signature of Patient/Parent/Guardian · Firma del Paciente/Padre/Guardian

Date/Fecha