

Manteca Dental Care

Rick Van Tran DDS & Associates

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www.mantecadentistry.com

Insurance Information/Información de Seguro

Please fill out information about the insured/Complete la información de la persona que tiene la aseguranza

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

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

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

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

Assignment of Benefits and Release for Payment

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance company and assign directly to Dr. Rick Van Tran, DDS 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.

Date/Fecha: _____

Signature of Patient, Parent or Guardian
Firma del Paciente, Padre, o Guardian