H. Vincent Lai, DDS
20652 Redwood Road Castro Valley, CA 94546
(510) 733-6282

CONFIDENTIAL PATIENT INFORMATION

Date_____

Patient's Name_____**Birthdate**_____ [ ]M [ ]F
First MI Last

If minor, give name of parent or legal guardian_____ **Relationship**_____

Address_____
Street City Zip

E-mail address: _____ **Patient is:** [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Minor

Driver's Lic. No. _____**SSN**_____ **Home#**_____ **Cell #**_____

Employer _____ **Occupation**_____**Bus #**_____

Spouse's Name_____ **Birthdate**_____**SSN**_____

Employer_____ **Occupation**_____**Bus #**_____

EMERGENCY CONTACT

Name_____ **Relationship to patient**_____ **Ph #**_____

DENTAL INFORMATION

Former Dentist_____ **Ph #**_____

Why are you changing Dentist?_____

Purpose of Appointment_____

Whom may we thank for referring you?_____

FINANCIAL INFORMATION and POLICY

Person Responsible for this account_____ **Ph#**_____

DENTAL INSURANCE INFORMATION

Primary Insurance Plan Name: _____

Name of Insured_____
Last First MI

Insured's Birth Date_____ **SSN**_____ **Group #**_____

Secondary Insurance Plan Name: _____

Name of Insured_____
Last First MI

Insured's Birth Date_____ **SSN**_____ **Group #**_____

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our financial policy. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by the office manager. For your convenience, we accept most Dental Benefits, Cash, Check, Visa, MasterCard, Discover Card, American Express, and CareCredit payment plans. We will gladly process your insurance claim form. You must realize, however, that your insurance is a contract between you and the insurance company. We are not responsible for your contract with your insurance company. Not all services are covered benefits with your insurance. We try our very best to accurately estimate your copayment for services based on the information given to us by your insurance carrier. However, sometimes there is a need to send you a statement for your share of cost. Every dental insurance policy has a maximum benefit. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount after services have been paid to all offices involved.
I hereby authorize that I, and/or my dependents(s) have insurance coverage with the plan(s) named above and assign directly to Dr. H. Vincent Lai 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 also authorize the use of my health care information to the above-named Insurance Compay(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges and/or attorney fees.

Signature of Patient,Parent, or Guardian:_____ ***Date***:_____