PATIENT INFORMATION

NAME:________________________________ TODAY'S DATE:__________________

HOME PHONE NUMBER:___________________ CELL PHONE:__________________

ADDRESS:______________________________ APARTMENT #:__________________

CITY:___________________________ STATE:________________ ZIP CODE:

SEX: ☐ M ☐ F _____________ DOB: _____/______/_____ **ID : ------------------------------------**

PARENT INFORMATION (IF PATIENT IS A MINOR):

NAME: ________________________________ HOME PHONE NUMBER: ____________________

ADDRESS: _____________________________ CELL PHONE: __________________

CITY: ______________________ STATE: ________________ ZIP CODE:________________

SEX: ☐ M ☐ F BIRTHDATE:______/______/______ **ID : ……………………………………..**

DENTAL INSURANCE:

INSURANCE COMPANY: ______________________ SS/ID #:______________________

SUBSCRIBER'S NAME: _____________________ DOB: _____/______/_______

RELATIONSHIP TO PATIENT: ______________________

ASSIGMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to Dr. Nguyen 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.

The above-named dentist 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 payable for related services. You must pay your estimated portion, deductible, and/or co-pay at the time service is rendered.

______________________________________ ________________

Signature of patient, parent, guardian or personal representative Date

____ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

OFFICE POLICIES:

We ask you to show consideration by notifying our office at least **48 hours in advance** if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the Dentist.

_____________________ _______________

SIGNATURE DATE

HEALTH HISTORY

Place a mark (✓) to indicate if you have had any of the following:

☐ AIDS/HIV	☐Congenital Heart Lesions	☐Hepatitis Type______	☐ Psychiatric Care
☐ Anemia	☐ Cortisone Treatments	☐ Herpes	☐ Radiation Treatment
☐Arthritis, Rheumatism	☐ Cough, persistent or bloody	☐ High Blood Pressure	☐ Respiratory Disease
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaundice	☐ Rheumatic Fever
☐Asthma	☐ Emphysema	☐ Jaw Pain	☐ Scarlet Fever
☐ Back problems	☐ Epilepsy	☐Kidney Disease	☐ Shortness of Breath
☐Blood Disease	☐ Fainting or dizziness	☐ Liver Disease	☐Sinus Trouble
☐Cancer	☐ Glaucoma	☐Low Blood Pressure	☐ Skin rash
☐ Chemical Dependency	☐ Headaches	☐ Mitral Valve Prolapse	☐ Special Diet
☐Chemotherapy	☐ Heart Murmur	☐ Nervous Problems	☐ Stroke
☐ Circulatory Problems	☐Heart Problems	☐ Pacemaker	☐ Swollen Feet or Ankles
☐Swollen Neck Glands	☐Thyroid Problems	☐Tonsillitis	☐ Tuberculosis
☐Tumor or growth on head/neck	☐Ulcer	☐Venereal Disease	☐Weight loss, unexplained

MEDICATIONS	ALLERGIES
________________________________	________________________________
________________________________	________________________________

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: ______________ Are you nursing? ☐ Yes ☐ No

Taking Birth Control Pills? ☐ Yes ☐ No

I ______________________________ certify that the above medical information provided above is correct to the best of my knowledge.

______________________________ ________/________/ ______

SIGNATURE **DATE**

PATIENTS WITH NO INSURANCE $79 VISIT

THE INITIAL VISIT INCLUDES X-RAYS, A COMPLETE EXAM, AND A SIMPLE CLEANING (IF YOU ARE DIAGNOSED WITH PERIODONTAL DISEASE, THE SIMPLE CLEANING WILL NOT BE COMPLETED). WE WILL PROVIDE YOU WITH AN ESTIMATE DEPENDING ON THE TYPE OF CLEANING THAT IS RECOMMENDED. WE WILL ALSO OFFER A 20% DISCOUNT ON ANY WORK NEEDED, EXCEPT ORTHODONTIC TREATMENT, BLEACHING TREATMENT, AND ANY DENTAL PRODUCT.

I ______________________ UNDERSTAND THE CONDITIONS THAT APPLY TO THE STATEMENT WRITTEN ABOVE.

________________________________ ____________________________

SIGNATURE DATE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we _may not be allowed_ to process your insurance claims.

Date: ___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

___________________________________ ___________________________________

Please **_print_** name of Patient Please **_sign_** for Patient / Guardian of Patient

___________________________________ ___________________________________

Legal Representative / Guardian Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Last Name ☐ Other ____________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ___________________________ Relationship: _______________________________

Name: ___________________________ Relationship: _______________________________

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

HIPAA made EASY™

APPOINTMENT POLICY

Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know 48 hours in advance, failure to do so will result in a fee of $50 for any missed appointment. The missed appointment fee must be paid prior to future office visits.

(Please Initial)____________

CONSENT FOR DENTAL PROCEDURES

I hereby request and authorize the dentist at First Family Dental and the dentist's auxiliaries to perform all dental treatment and surgery as indicated in my dental records and treatment plan. I understand and authorize for these procedures, which are deemed necessary and advisable in the dentist's judgment. I also authorize the administration of drugs and anesthetics, as may be deemed advisable by the dentist.

COUPONS & SPECIALS

On occasion, our practice offers discounts or coupons to help make dental care more affordable for non-insurance holding patients. Our $79 special is structured to help assist patients that obtain routine dental care every 6 months in maintaining optimal dental care. The $79 special covers a complete exam, simple cleaning, and 4 bite wing x-rays.

This offer is not valid for patients who are diagnosed with periodontal disease by the dentist, as these patients require an intensive deep cleaning; a simple cleaning will not help and is not sufficient for the patient's oral health. The doctor will not perform the simple cleaning in these instances .

(Please Initial) ____________

DENTAL INSURANCE

Dental insurance is a contract between the employer and the patient. It has **NO CONNECTION** to the provider of dental treatment. The extent of the coverage varies from company to company, and sometimes even within a company.

Although it is not required, as a courtesy, we will prepare and submit your insurance claim forms at no cost to you. At your request, we might also provide estimates that show the expected insurance reimbursement and patient share for every procedure. This is only an **estimate**.
You are ultimately responsible for the cost of all professional services rendered, regardless of estimate, if insurance does not pay their portion.

In the event that we have services of an outside collection agency to obtain payment, you will be responsible for all fees charged to our practice by the collection agency.

I fully understand my financial obligation and responsibility to adhere to the appointment policy.

Patient Signature or Parent/Gaurdian signature if patient is a minor:_____________________________

Date: ________________________ Name: ____________________________________

DENTAL HISTORY

Reason for today's visit: ____________________

____

____

Former Dentist: ______________________________

City/State: __________________________________

Date of last dental visit: ____________________

Date of last dental X-rays: ___________________

Place a mark on 'yes' or "no" if you have any of the following.

Bad Breath: Yes☐ No ☐

Bleeding Gums: Yes☐ No☐

Blisters on lips or mouth: Yes ☐ No☐

Cigarette, pipe cigar smoking: Yes☐ No☐

Chewing tobacco: Yes☐ No☐

Clicking or popping jaw: Yes☐ No☐

Dry mouth: Yes☐ No☐

Build-up between teeth: Yes☐ No☐

Grinding teeth: Yes☐ No☐

Gums swollen or tender: Yes☐ No☐

Loose teeth or broken fillings: Yes☐ No☐

Pain when brushing: Yes☐ No☐

Orthodontic treatment: Yes☐ No☐

Periodontal treatment: Yes☐ No☐

Sensitivity to cold: Yes☐ No☐

Sensitivity to heat: Yes☐ No☐

Sensitivity to sweets: Yes☐ No☐

Sensitivity when biting: Yes☐ No☐

Sores or growths in mouth: Yes☐ No☐

How often do you floss?

____

How often do you brush?

____