PATIENT INFORMATION

NAME:______________________________ HOME PHONE NUMBER: ____________________

ADDRESS:____________________________________ CELL PHONE: ______________________

CITY: ________________________________ STATE: ___________________

ZIP CODE:__________________ EMAIL: __________________________________

SEX:☐ M ☐ F DOB: _______/_________/________

PARENT INFORMATION (IF PATIENT IS A MINOR):

NAME: ______________________________________ HOME PHONE NUMBER: _______________________

ADDRESS: ____________________________________ CELL PHONE: ____________________

CITY: ___________________________ STATE: ____________________ ZIP CODE: ___________________

SEX:☐ M ☐ F BIRTHDATE:________/_________/________

DENTAL INSURANCE:

INSURANCE COMPANY: ___________________________ SS/ID #:__________________________

SUBSCRIBER'S NAME: ________________________ DOB: _____/_______/__________

RELATIONSHIP TO PATIENT: ___________________________

ASSIGNMENT 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. Cancellation of an appointment **without 48 hour notice/no shows may be subject to $25 cancellation fee**.

__________________________ ____________________

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

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____

ALLERGIES

____

____

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

__________________________   ______/______/ _____

SIGNATURE   **DATE**

Women:

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

Taking Birth Control Pills? ☐ Yes ☐ No

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 25% 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