DENTAL 360

Welcome to Our Practice

Referral By_____ Date _____

PATIENT INFORMATION

□ Mr. □ Mrs. □ Ms. □ Dr. First Name_____M.I._____Last Name _____

Sex: □ Male □ Female Birth Date_____Age_____Driver's Lic # _____

Street_____City_____State_____Zip_____

Home Tel_____Bus Tel_____Cell # _____

Soc Sec#_____Email_____

In case of emergency, please contact_____Tel_____Relation _____

SPOUSE / OTHER GUARANTOR INFORMATION

First Name_____Last Name_____Relationship_____

Soc Sec #_____Birth Date_____Age _____ Driver's Lic # _____

Street_____City_____State_____Zip_____

Home Tel_____Bus Tel_____Cell # _____

Employer_____Employer address _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Type □ Dental □ Medical

Insurance Co. Name_____Insurance Co. Tel _____

Group #_____Group Name_____Subscriber ID # _____

Subscriber Name_____Relationship_____Soc Sec # _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Type □ Dental □ Medical

Insurance Co. Name_____Insurance Co. Tel _____

Group #_____Group Name_____Subscriber ID # _____

Subscriber Name_____Relationship_____Soc Sec # _____

DENTAL INFORMATION

Reason for this visit_____Are you in pain? □ Yes □ No For How Long? _____

Please indicate any of the following problems by checking off the corresponding box

□ Discomfort, clicking, or popping in jaw
□ Red, swollen, or bleeding gums
□ A removable dental appliance
□ Blisters / sores in or around the mouth
□ Prolonged bleeding from an injury / extraction
□ Recent infections or sore throat
□ Loose / Shifting teeth
□ Lost / broken filling(s)
□ Teeth grinding/clenching
□ Ringing in ears
□ Broken / Chipped tooth
□ Gum Disease
□ Difficulty closing jaw
□ Food caught between teeth
□ Stained teeth
□ Locking Jaw
□ Bad breath
□ Burning tongue / lips
□ Toothache
□ Difficulty opening jaw
□ Swelling / lumps in mouth

□ My teeth are sensitive to □ Hot □ Cold □ Sweets □ Biting □ Other _

Last dental exam_____Last dental x-rays_____Times a day you brush?___ Times a week you floss?__ What type of toothbrush bristles do you use? □ Soft □ Medium □ Hard

MEDICAL HISTORY

Are you in good health? □ Yes □ No Height_____Weight_____

Are you under the care of a physician? □ Yes □ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? □ Yes □ No

Have you had any illness, operation, or been hospitalized in the past year? □ Yes □ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? □ Yes □ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
□	□	Rheumatic fever	□	□	Mental health problems	□	□	Blood transfusion
□	□	High blood pressure	□	□	Problems w/ immune system	□	□	Blood disorder
□	□	Low blood pressure			*(possible from med/surg)*	□	□	Bruise easily
□	□	Mitral valve prolapse	□	□	Delay in healing	□	□	Eye disease / Glaucoma
□	□	Heart murmur	□	□	Hay fever / Sinus problems	□	□	Jaundice / Liver disease
□	□	Chest pain / Angina	□	□	Snoring / Sleep apnea	□	□	Hepatitis
□	□	Heart attack (s)	□	□	Respiratory problems	□	□	Gallbladder trouble
□	□	Irregular heart beat	□	□	Tuberculosis	□	□	Fainting spells
□	□	Cardiac pacemaker	□	□	Emphysema	□	□	Convulsions Epilepsy
□	□	Heart Surgery	□	□	Stroke	□	□	Damage heart valves
□	□	Thyroid trouble	□	□	Chronic fatigue / Night sweet	□	□	A history of drug abuse
□	□	Low blood sugar	□	□	Anemia	□	□	Abnormal bleeding
□	□	Trouble climbing 1-2 flights or stairs	□	□	Kidney trouble	□	□	Asthma
□	□	Bleeding tendency	□	□	Infectious mononucleosis	□	□	Contagious diseases
□	□	Swollen ankles	□	□	Arthritis / Joint disease	□	□	Prosthetic implant
□	□	Pneumonia/Bronchitis/Chronic cough	□	□	Osteoporosis / Osteopenia	□	□	Osteonecrosis
□	□	Tumor or growth	□	□	Cancer/Radiation/Chemotherapy	□	□	Stomach ulcers

MEDICATION & ALLERGIES

Please list any medication(s) you are taking (including natural, herbal, or homeopathic products)

Medication_____ Dosage_____Frequency_____

Medication_____ Dosage_____Frequency_____

Medication_____ Dosage_____Frequency_____

Medication_____ Dosage_____Frequency_____

Are you taking blood thinners (*Coumadin, Aspirin*)? □ Yes □ No

Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, or Aredia within the past 12 years? □ Yes □ No

Are you allergic to, or had a reaction to

□ Penicillin □ Sulfa drugs □ Amoxicillin

□ Local anesthetic (numbing med) □ Aspirin □ Latex

□ Sodium pentothal/Valum/Other tranq. □ Soy/Eggs/Yolk □ Sulfites

Please list any other medication or antibiotic you are allergic to

_____

Please list any allergies other than drug allergies

_____

Below are for women only (*Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods or birth control.)*

Are you pregnant? □ Yes □ No Expected delivery date _____

Are you nursing? □ Yes □ No Are you taking birth control pills? □ Yes □ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Print Patient Name_____Patient Signature_____Date_____

(*Parent or Guardian if minor*)

Email : _____

Office Policy and HIPPA

Cancellation & Broken Appointments Policy

Two business days (48 hours) advanced notice is required for any change or cancellation of your scheduled appointment. This allows us the time to fill your appointment by others who are in need of dental care.

For patients who cancel their appointments less than 2 business days (48 hours), or don't show up for the appointment, a fee of $75 will be charged to the account. Please note that your account will only be charged if you do not honor our Cancellation and Broken Appointment Policy.

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. Please give us the same consideration when you need to reschedule or cancel your appointment. **INITIAL** _____

Signature Release Statement

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to **Dr. Titus Tang / Dental 360**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **INITIAL** _____

Payment and Financial Policy

All known and estimated co-payments are due at the time services. A returned check is subjected to a $25 fee.

DENTAL INSURANCE: Our estimates regarding your dental insurance are given as carefully as possible. These estimates are based on current information available and past payment history of insurance companies. However, your insurance carrier will ultimately decide on the benefit to be released. Our financial arrangement will include your estimated dental insurance coverage and you are responsible for the total treatment fee as listed on the treatment page.

Once your insurance company has processed the insurance claim, you will be billed for any outstanding balance. If you have questions about insurance reimbursement, it is your responsibility to contact your insurance provider. Once a claim has been closed your balance is due. Claims will be considered closed, regardless of payment, 120 days from the original date of service. **INITIAL** _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices and Consent have been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.
INITIAL _____

_____
Print Patient Name ***(****Parent or Guardian if minor*)

_____ _____
Signature of Patient ***(****Parent or Guardian if minor****)*** **Date**

Smile Evaluation

1. Do you like the way your teeth look? ○ Yes ○ No
Explain: _____

2. Are you happy with the color of your teeth? ○ Yes ○ No
Explain: _____

3. Would you like your teeth to be whiter? ○ Yes ○ No
Explain: _____

4. Would you like your teeth to be straighter? ○ Yes ○ No
Explain: _____

5. Do you have spaces between your teeth that you would like closed?

If so, ○ Upper ○ Lower ○ Both?

6. Would you like your teeth to be longer? ○ Yes ○ No
Explain: _____

7. Do you like the shape of your teeth? ○ Yes ○ No
Explain: _____

8. Do you have missing teeth that you would like replaced? ○ Yes ○ No
Explain: _____

9. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? ○ Yes ○ No

10. If you could change anything about your smile, what would you change?

_____