

## **Welcome to Our Practice**

				Date	9
PATIENT INFORMATION					
□ Mr. □ Mrs. □ Ms. □ Dr. First Na	ame	M.I.	Last Name	e	
Sex: □ Male □ Female Birth Date		Age	Driver's Lic	#	
Street		City		State	Zip
Home Tel	Bus Tel		C	ell #	
Soc Sec#		Email			
In case of emergency, please contact _			_ Tel	Relatio	on
SPOUSE / OTHER GUARA	NTOR INFORMA	TION			
First Name	Last Nam	ne		Relationship _	
Soc Sec#					
Street		City		State	Zip
Home Tel	Bus Tel		C	ell #	
Employer		Employer ac	ldress		
PRIMARY DENTAL INSURA	ANCE INFORMA	TION			
PRIMARY DENTAL INSURA Insurance Type   Dental   Medical Insurance Co. Name	ANCE INFORMA	TION	Insurance Co. To	el	
PRIMARY DENTAL INSURA	ANCE INFORMA	TION	Insurance Co. To	el Subscriber ID #	
PRIMARY DENTAL INSURA Insurance Type   Dental   Medical Insurance Co. Name	ANCE INFORMA	TION  Relationship	Insurance Co. To	el Subscriber ID #	
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PRIMARY DENTAL INSURA Insurance Type   Dental   Medical Insurance Co. Name	ANCE INFORMA  Group Name  BURANCE INFOR	TION  Relationship	Insurance Co. To	el Subscriber ID # Soc Sec #	

DENTAL INFORMATION						
	Ana ana in a sin O	No. Facilian Lanco				
Reason for this visit Are you in pain? □ Yes □ No For How Long?						
Please indicate any of the following problems		Otalin and to att				
Discomfort, clicking, or popping in jaw	□ Lost / broken filling(s)	□ Stained teeth				
□ Red, swollen, or bleeding gums	□ Teeth grinding/clenching	□ Locking Jaw				
□ A removable dental appliance	□ Ringing in ears	□ Bad breath				
□ Blisters / sores in or around the mouth	□ Broken / Chipped tooth	□ Burning tongue / lips				
□ Prolonged bleeding from an injury / extraction	□ Gum Disease	□ Toothache				
□ Recent infections or sore throat	□ Difficulty closing jaw	□ Difficulty opening jaw				
□ Loose / Shifting teeth	<ul> <li>Food caught between teeth</li> </ul>	□ Swelling / lumps in mouth				
☐ My teeth are sensitive to ☐ Hot ☐ Cold ☐ Swe		<del>_</del>				
Last dental exam Last dental	x-rays Times a day you brus	h? Times a week you floss?				
What type of toothbrush bristles do you use? $\ \square$ S	oft □ Medium □ Hard					
MEDICAL HISTORY						
Are you in good health? □ Yes □ No Height _	Weight	_				
Are you under the care of a physician? □ Yes □ N	0					
Has a physician or previous dentist recommended	d that you take antibiotics prior to your dental trea	atment? □ Yes □ No				
Have you had any illness, operation, or been hosp	pitalized in the past year? □ Yes □ No					
Have you, or a family member, had any unusual o		s □ No				
Do you have, or have you had, any of the follo	_					
YN	YN	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	A1				
		•				
Trouble climbing 1-2 flights or stairs      Reading tendency	□ □ Kidney trouble	□ □ Asthma				
Bleeding tendency      Swellen ankles	Infectious mononucleosis      Athritis / loint diagons	□ □ Contagious diseases				
□ □ Swollen ankles	□ Arthritis / Joint disease	□ Prosthetic implant				
□ □ Pneumonia/Bronchitis/Chronic cough	□ □ Osteoporosis / Osteopenia	□ □ Osteonecrosis				

 $\ \ \Box \ \ Cancer/Radiation/Chemotherapy$ 

 $\hfill\Box$   $\Box$  Tumor or growth

□ □ Stomach ulcers

MEDICATION & ALLERGIES			
Please list any medication(s) you are taking (	(including natural, herbal, or l	homeopathic products)	
Medication		Frequency	
Medication		Frequency	<del></del>
Medication	Dosage	Frequency	<del></del>
Medication	Dosage	Frequency	
Are you taking blood thinners (Coumadin, Aspiri	n)? □ Yes □ No		
Are you taking, or have you ever taken, any bon within the past 12 years? □ Yes □ No	e density meds. or bisphosphor	nates, such as Fosamax, Boniva, Actonel, I\	/ Zometa, or Aredia
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 allergies other than drug allergies  Below are for women only (Women note: antibiot Consult your physician / gynecologist for assistance res  Are you pregnant? □ Yes □ No  Are you nursing? □ Yes □ No	tics (such as penicillin) may alter the garding additional methods or birth o Expected delivery		
I certify that I have read and I understand the quality have been answered to my satisfaction. I will not that I have made in the completion of this form.	uestions above. I acknowledge ot hold my doctor, or any other r	that my questions, if any, about the inquiremember of his/her staff, responsible for any	s set forth above errors or omissions
Print Patient Name	Patient Signatur	re Dato	e
(Parent or Guardian if minor)	ation orginatal		
Email:			
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## 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.

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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 <b>Dr. Titus Tang / 59B Dental</b> . 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. <b>INITIAL</b>
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.
<u>DENTAL INSURANCE</u> : 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)

**Date** 

Signature of Patient (Parent or Guardian if minor)

## **Smile Evaluation**

Do you like the way your teeth look?  Explain:	Yes	No —
Are you happy with the color of your teeth?  Explain:	Yes	No
3. Would you like your teeth to be whiter?  Explain:	Yes	No
4. Would you like your teeth to be straighter? Explain:	Yes	No
5. Do you have spaces between your teeth that you would like close	ed?	
If so, Upper Lower Both?		
6. Would you like your teeth to be longer? Explain:	Yes	No
7. Do you like the shape of your teeth? Explain:	Yes	No
8. Do you have missing teeth that you would like replaced?  Explain:	Yes	No
9. Do you have old silver fillings that you would like to be replaced v	with	
tooth-colored fillings?	Yes	No
10. If you could change anything about your smile, what would you	change?	