Dr's Signature

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name _____DOB:_____Phone:_____

If minor, parents names_____ Email:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation

_____

Emergency Contact Name _____ #

_____

How would you like to be contacted:❑CALL❑TEXT❑EMAIL ❑No Preference

Whom may we thank for referring you to our office?❑Google❑Yelp❑Postcard ❑Location

❑Current Patient
Name:_____

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑Not covered by dental insurance

Dental Insurance Co._____Your Social Security or ID number: _____

Covered by a spouse's/Parent's insurance? ❑ yes❑ noSpouse's/Parent's Name_____

Spouse's/Parent's dental insurance company _____ Group number _____

Spouse's/Parent'sBirthday _____ Social Security or ID number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

YES NO (Please check **YES** OR**NO**)

- ❑ ❑Cancer or tumor (please circle)
- ❑ ❑Heart ailment or angina
- ❑ ❑Heart murmur, mitral valve prolapse, heart defect
- ❑ ❑Rheumatic fever or rheumatic heart disease
- ❑ ❑Artificial joint or valve
- ❑ ❑High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑Pacemaker
- ❑ ❑Tuberculosis or other lung problems
- ❑ ❑Kidney disease
- ❑ ❑Hepatitis or other liver disease
- ❑ ❑Alcoholism
- ❑ ❑Blood transfusion
- ❑ ❑Diabetes
- ❑ ❑Neurologic condition
- ❑ ❑Epilepsy, seizures, or fainting spells (please circle)
- ❑ ❑Emotional condition
- ❑ ❑Arthritis
- ❑ ❑Herpes or cold sores
- ❑ ❑AIDS or HIV positive
- ❑ ❑Migraine headaches or frequent headaches
- ❑ ❑Anemia or blood disorders
- ❑ ❑Abnormal bleeding after extractions, surgery
- ❑ ❑Hayfever or sinus trouble
- ❑ ❑Allergies or hives
- ❑ ❑Asthma

Do you smoke or use chewing tobacco? ❑YES❑ NO

Are you allergic to, or have you reacted adversely to any of the following?

YES NO

- ❑ ❑Latex materials
- ❑ ❑**Penicillin or other antibiotics**
- ❑ ❑Local anesthetics ("Novocain")
- ❑ ❑Codeine or other narcotics
- ❑ ❑Sulfa drugs
- ❑ ❑Barbiturates, sedatives, or sleeping pills
- ❑ ❑Aspirin
- ❑ ❑Other:_____

Are you taking any of the following?

YES NO

- ❑ ❑Aspirin
- ❑ ❑Anticoagulants (blood thinners)
- ❑ ❑Antibiotics or sulfa drugs
- ❑ ❑High blood pressure medicine
- ❑ ❑Antidepressants or tranquilizers
- ❑ ❑Insulin, Orinase, or other diabetes drug
- ❑ ❑Nitroglycerin
- ❑ ❑Cortisone or other steroids
- ❑ ❑Osteoporosis (bone density) medicine
- ❑ ❑Other:_____

_____

Women:

Y❑ N❑May be pregnant/Trying to get pregnant

Expected delivery date: _____

Y❑YN❑Taking hormones or contraceptives

Are you in dental PAIN now??:_____

Do you have any disease, condition, or problem not listed above?_____

Last Dental Exam:_____ Last Dental xrays:_____ Last Dental Cleaning:_____

Signature of patient (or parent) _____ Date

_____

Practice Policies

We at Smile 32 Dental are dedicated to serving you in caring for your oral health. We take great pride and care in providing the best dental care to you and your family. Therefore, we will be more than happy to assist you with any financial matter related to you dental needs.

Appointments:

- **Patient satisfaction and your time are very important to us. Every effort is made to stay on schedule so please arrive as scheduled. If you are 15 mins late, we will reschedule your appointment.**
- **Advanced notice of 48 working hours is requested to cancel appointments if necessary.**
- **A $75.00 fee will be charged for failed appointments when advanced notice has not been given.**

Payment Options:

We ask for payment in full at each dental visit.
To accommodate you with this we accept the following methods of payment:Cash , ATM/Check Card, Visa, MC, Amex, Disc, Care Credit, (with prior approval before your appointment)

Insurance/Finances :

We accept most insurance plans. Insurance plans are unique and adhere to specific covered and non-covered procedures depending upon your individual plan. We do our best to provide accurate treatment and insurance estimates with the information provided us and from our initial contact with your insurance company. For your convenience we will prepare Treatment Estimates in advance of dental services. Treatment is recommended regardless of insurance deductibles, maximums and plan limitations. In order to keep our fees to you as low as possible we ask that deductibles and co-payments be paid at the time of service. For your convenience an estimate for dental care will be prepared prior to scheduled appointments to help you avoid unexpected balances. Please be advised that you are responsible for all balances not paid by your insurance company. Your assistance may be necessary to receive payment from your insurance in a timely manner.

Delinquent Accounts:

Account balances are due upon receipt of practice statements. A Service Fee of $25 will be charged for Unapproved Card Payments. Unpaid balances where no agreement has been made with our Billing Department to extend payment may be transferred to a Collection Agency without further notice.

I acknowledge that I have received and do understand Smile 32 Practice Policies.

_____ _____ _____

Patient Name Signature Date

Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have received a copy of Smile 32 Dental Notice of Privacy Practices (Notice) on this date indicated. If you have any questions regarding the information in Smile 32 Dental Notice of Privacy Practices, please do not hesitate to contact a staff member.

Patient Name (printed):_____

Signature:_____

If Patient Representative, Name (Printed):_____Relationship to Patient:_____-_____

Date Notice Received:_____

THE DENTAL BOARD OF CALIFORNIA DENTAL MATERIAL FACT SHEET

The following document is the Dental Board of California's Dental Materials Fact sheet.
The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact sheet, and its linkage to the DCA website does not constitute an endorsement to the content of this document.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE DENTAL MATERIAL FACT SHEET

Signature:_____Date:_____

As required by chapter 801, statues of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be complete guide to dental materials science.

CONSENT FOR DENTAL TREAMENT

Consent for Dental Treatment I request and authorize Dr. Nguyen and his staff to provide me with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my dental health. At that time I request and authorize Dr. Nguyen and his staff to complete the accepted treatment for myself, (or my child).

Signature:_____Date:_____