NEW PATIENT INFORMATION

Please complete all sections. Clear and accurate information helps us provide safer care.

1. About You

Today's Date: _____

E-mail Address: _____

Legal Name: _____

Preferred Name: _____

Birthdate: ____ / ____ / _____

Age: _____ SS #: _____

☐ Male ☐ Female ☐ Other / Prefer not to say

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

City: _____

State: _____ ZIP: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Extension: _____ Driver's License #: _____

Employer: _____

Employer's Address: _____

How long employed there? _____

Occupation: _____

Best time and method to reach you: _____

Referred by: _____

Other family members seen by this office: _____

Previous / Present Dentist: _____

Date of Last Visit: ____ / ____ / _____

2. Spouse / Responsible Party

Spouse / Partner Name: _____

Birthdate: ____ / ____ / _____

Employer: _____

Contact #: (____) _____

SS #: _____

Driver's License #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Relationship to Patient: _____

Billing Address: _____

SS #: _____

Employer: _____

Driver's License #: _____

DENTAL INSURANCE & EMERGENCY CONTACT

3. Primary Dental Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Emergency Contact

Name of person who lives near you and should be contacted in an emergency:

_____

Relationship: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell Phone: (____) _____

MEDICAL HISTORY

4. Physician and Current Health

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Work Phone: (____) _____ Date of Last Visit: ____ / ____ / _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Current physical health: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription, over-the-counter, or supplemental drugs? ☐ Yes ☐ No

Please list each medication: _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you ever taken Fosamax or another bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore, hold your breath while sleeping, or wake up gasping for breath? ☐ Yes ☐ No

For Women

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Medical Conditions

Mark Yes or No for each condition.

☐ Y ☐ N Anemia / Radiation Treatment
☐ Y ☐ N Artificial Bones / Joints / Valves
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer / Chemotherapy
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Drug / Alcohol Abuse
☐ Y ☐ N Emphysema / Glaucoma
☐ Y ☐ N Epilepsy / Seizures / Fainting Spells
☐ Y ☐ N Fever Blisters / Herpes
☐ Y ☐ N Heart Attack / Stroke
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery / Pacemaker
☐ Y ☐ N Hemophilia / Abnormal Bleeding
☐ Y ☐ N Hepatitis
☐ Y ☐ N High / Low Blood Pressure
☐ Y ☐ N HIV+ / AIDS
☐ Y ☐ N Hospitalized for Any Reason
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Psychiatric Treatment
☐ Y ☐ N Rheumatic / Scarlet Fever
☐ Y ☐ N Severe / Frequent Headaches
☐ Y ☐ N Shingles
☐ Y ☐ N Sickle Cell Disease / Traits
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcers / Colitis
☐ Y ☐ N Venereal Disease

Please list any serious medical condition(s) you have ever had:

_____

MEDICAL & DENTAL HISTORY - CONTINUED

Allergies

Mark Yes or No for each allergy.

☐ Y ☐ N Aspirin	☐ Y ☐ N Codeine	☐ Y ☐ N Dental Anesthetics
☐ Y ☐ N Erythromycin	☐ Y ☐ N Jewelry / Metals	☐ Y ☐ N Latex
☐ Y ☐ N Penicillin	☐ Y ☐ N Tetracycline	☐ Y ☐ N Other

Please list any other drugs or materials to which you are allergic:

_____

5. Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

Do you now, or have you ever, experienced pain or discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Current dental health: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

How many times a week do you floss? _____ How many times a day do you brush? _____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Patient Authorization

I understand that the information I have provided is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature: _____ **Date:** _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Office Use Only

I verbally reviewed the medical / dental information with the patient. Initials:

_____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

Date: _____ Comments: _____ Signature: _____

PATIENT CONSENT TO TREATMENT

By reading and signing this form, I confirm that English is the language I understand and use to communicate.

1. Drugs, Medications and Anesthesia

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, including redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, or cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by alcohol or other drugs. I have been advised not to consume alcohol or operate a vehicle or hazardous device while taking medications or drugs, or until fully recovered from their effects, including at least twenty-four (24) hours after release from treatment.

I understand that injection of a local anesthetic may occasionally cause prolonged or persistent anesthesia, numbness, or irritation at the injection site.

If I elect nitrous oxide, Atarax, chloral hydrate, Xanax, or another sedative, risks may include loss of consciousness, airway obstruction, anaphylactic shock, or cardiac arrest. Someone must drive me home after sedation and observe me closely for 8 to 10 hours.

Patient Initials: _____

2. Hygiene and Periodontics (Tissue and Bone Loss)

I understand that the long-term success of treatment and the status of my oral condition depend on proper oral hygiene, including brushing, flossing, and regular recall visits.

I understand that periodontal disease is a serious condition that causes gum and bone inflammation and/or loss and may lead to tooth loss or other complications. Treatments have a high degree of success but cannot be guaranteed, and treated teeth may occasionally require extraction.

Patient Initials: _____

3. Removal of Teeth

I understand that the purpose of the procedure or surgery is to treat diseased oral tissues and that, without treatment, my condition will probably worsen.

Potential risks include post-operative discomfort, swelling, prolonged bleeding, sensitivity, gum shrinkage, tooth looseness, delayed healing or dry socket, infection, injury to adjacent teeth or tissues, limited opening or jaw-joint problems, retained root fragments or bone spicules, bone fracture, sinus opening, and nerve injury causing itching, numbness, or burning that may persist temporarily or, rarely, permanently.

I consent to the treatment, procedure, or surgery explained to me and to other procedures the doctor considers necessary to complete the planned operation. I authorize the doctor to use professional judgment if unforeseen conditions arise, including referral to another dentist or specialist. Referral costs are my responsibility.

Patient Initials: _____

PATIENT CONSENT TO TREATMENT - CONTINUED

4. Fillings

I have been advised of the need for silver or composite fillings to replace tooth structure lost to decay. Fillings may need replacement due to wear. If little tooth structure remains or existing tooth structure fractures, more extensive treatment such as root canal therapy, post and build-up, or a crown may be required at an additional charge.

I understand that silver amalgam restoration is an accepted procedure under American Dental Association guidelines. The advantages and disadvantages of alternative materials have been explained to me.

Patient Initials: _____

5. Endodontic Treatment (Root Canal Therapy)

The purpose and method of root canal therapy, reasonable alternatives, and the consequences of no treatment have been explained to me. After root canal therapy, the tooth may be brittle and must be protected against fracture with a crown or other restoration.

Risks may include post-treatment discomfort, swelling, infection, restricted jaw opening, breakage of root-canal instruments, perforation of the root canal, additional surgery, premature tooth loss or extraction, and temporary or permanent numbness.

If an open-and-medicate or pulpotomy procedure is performed, I understand that it is not permanent treatment and that final root canal therapy must be completed. Failure to complete treatment may result in infection or tooth loss. Failed root canal therapy may require retreatment, root-end surgery, or extraction.

Patient Initials: _____

6. Crown and Bridge (Caps)

I understand that it may not be possible to match the color of natural teeth exactly with artificial teeth. During preparation for a crown, pulp exposure may occur and require root canal therapy.

Crowns and bridges must be kept clean with proper oral hygiene and periodic cleanings. Decay may otherwise develop under or around restoration margins and require additional treatment.

Patient Initials: _____

7. Dentures - Complete or Partial

Problems associated with dentures, including looseness, soreness, breakage, relining due to tissue changes, and the need for follow-up care, have been explained to me. Persistent sore spots should be examined promptly.

Surgical treatment such as tori removal, bone recontouring, or implants may be required for proper fit. Due to bone loss or other factors, I may never be able to wear dentures to my complete satisfaction.

Patient Initials: _____

8. Pedodontics (Child Dentistry)

I understand that accepted behavior-management procedures may include positive reinforcement and voice control.

The original form also describes hand-over-mouth exercise and physical restraint. Because these practices may be restricted or prohibited by current professional standards or law, the dental practice should obtain legal and clinical review before using this language.

Nitrous oxide and/or oral sedation may be administered to help a child relax. A parent or guardian must follow fasting instructions, escort the child home, and observe the child after sedation.

Local anesthetic may cause a child to bite the lip or cheek. The child should return for evaluation if swelling or pain does not resolve. A child who receives nerve treatment on a baby tooth should return within three months for evaluation, and extraction may later be required.

Patient Initials: _____

9. Work to Be Done

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. No guarantee or assurance has been made regarding the treatment I have requested and authorized.

I understand that each dentist is individually responsible for the dental care rendered. No dentist other than the treating dentist or Kenneth Tran, D.D.S. is responsible for my dental treatment.

During treatment it may be necessary to change or add procedures because of conditions not discovered during examination, including root canal therapy following routine restorative procedures. I authorize the dentist to make necessary changes and additions.

Patient Initials: _____

FINAL ACKNOWLEDGMENT

I understand that no guarantee or assurance has been given that the proposed treatment will be curative or completely satisfactory.

I agree to cooperate with the doctor's recommendations while under care and understand that failure to do so may result in less than optimal results.

I certify that I have had the opportunity to read and understand this form, ask questions, and receive answers to my satisfaction.

I understand that this dental facility provides care without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age, or marital status, and protects patient privacy.

Patient / Guardian Signature: _____

Relationship: _____

Date: _____

Doctor: _____

Witness: _____

PATIENT FINANCIAL LIABILITY FORM

Patient Name: _____ Date of Birth: ____ / ____ / _____

We are happy you have joined our dental family. We look forward to providing quality dental care. Before treatment, please review and agree to the following terms.

Full payment is required for all services rendered. Payment for prior services and treatment is required before future non-emergency services may be provided. Payment is expected when services are rendered.

This office accepts Visa, MasterCard, and Discover. Checks are accepted with valid photo identification. Returned checks are subject to additional service fees. Extended payment plans may be offered with prior credit approval and must be arranged before treatment.

Unpaid accounts may be sent to collections if payment is not made within a reasonable period and may adversely affect credit. The patient agrees to pay fees incurred in pursuing delinquent balances. Non-emergency services may be denied for delinquent accounts, and collection activity may affect patient status with the practice.

Insurance Is Accepted Under the Following Conditions

All co-payments are due at the time of service. The patient agrees to pay deductibles, coinsurance, and services identified by the insurance carrier as patient responsibility.

Patient portions are billed after the practice receives the insurance carrier's statement regarding the claim. The patient is responsible for any remaining balance after payments made at the time of service and insurance benefits.

Claim payments denied by the insurance carrier become the patient's responsibility. The patient agrees not to withhold payment from the practice because of a dispute with the insurance carrier.

Verification of benefits is not a guarantee that an insurance carrier will pay a claim or the estimated amount. Patients are responsible for checking benefits before treatment. The carrier makes the final coverage determination.

Patients without insurance who pay by cash receive a 5% discount from the billable amount.

I have read the above information and agree to all terms and conditions.

Patient Signature: _____ **Date:** _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices explains how we may use or disclose protected health information.

The notice contains a patient-rights section describing your rights under the law. By signing this consent, you acknowledge that you have reviewed the notice before signing.

The terms of the notice may change. If they do, you may request an updated copy at your next visit.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The practice is not required to agree to every requested restriction, but will honor restrictions it accepts. HIPAA permits certain uses and disclosures for treatment, payment, and healthcare operations.

By signing this form, you consent to the use and disclosure of your protected health information. You may revoke this consent in writing; however, a revocation is not retroactive.

By Signing, I Acknowledge

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice may change its privacy policy as allowed by law.
- The practice may decline a requested restriction when the law permits.
- I may revoke this consent in writing, and future disclosures will then cease except as otherwise permitted by law.
- The practice may condition receipt of treatment on execution of this consent when permitted by law.

Communication Preferences

May we phone, e-mail, or send a text to confirm appointments? ☐ Yes ☐ No

May we leave a message on your home answering machine or cell phone? ☐ Yes ☐ No

May we discuss your dental condition with a member of your family? ☐ Yes ☐ No

If yes, list authorized family member(s): _____

This consent was signed by (print name): _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____