Patient Information

Patient Name _____ Date _____
Address _____
Mobile Phone _____ Work Phone _____
Home Phone _____ E-mail _____
Date of Birth _____ Social Security # _____
Drivers License # _____

Who May We Thank for Referring You to Our Office? _____

Responsible Party Information

Name _____ Relationship to Patient _____

Address _____

Mobile Phone _____ Home Phone _____

Date of Birth _____ Employer _____

Responsible Party SSN _____ Responsible Party DL # _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Phone _____

To the best of my knowledge, all preceding answers are correct and complete. I will inform your office of any changes at each appointment.

_____ _____

Patient Signature Date

Dental Questionnaire

Patient's Name _____ Date _____

Correct answers to the following questions will allow Dr. Linh Nguyen to treat you on a more individual basis, providing the care appropriate for your individual needs. Your answers will be considered CONFIDENTIAL.

1. Are you having any discomfort? Yes ___ No ___ Date of last visit? _____
2. Have you ever had any serious trouble associated with previous dentistry? Yes ___ No ___
3. Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)? Yes ___ No ___
5. How often do you brush your teeth? _____ Brush is: Soft ____ Medium ___ Hard ___
6. Do you have or have you ever had, any of the following:

Bleeding/sore gums	Yes ___ No ___	Loose teeth	Yes ___ No ___
Unpleasant taste/bad breath	Yes ___ No ___	Sensitivity to hot	Yes ___ No ___
Burning tongue/lips	Yes ___ No ___	Sensitivity to cold	Yes ___ No ___
Frequent blisters on lips/mouth	Yes ___ No ___	Sensitivity to sweets	Yes ___ No ___
Orthodontic treatment (braces)	Yes ___ No ___	Sensitivity to biting	Yes ___ No ___
Biting cheeks/lips	Yes ___ No ___	Food impaction	Yes ___ No ___
Clicking/popping jaw	Yes ___ No ___	Clenching/grinding	Yes ___ No ___
Difficulty opening/closing jaw	Yes ___ No ___	Change/shift in bite	Yes ___ No ___

7. These are important to me about my dental health: _____
8. What do you fear most about dental care (if anything)? _____

Circle One:

1. My mouth is… 3. I…
   a. Very comfortable a.
   b. Moderately comfortable
   c. Uncomfortable b.
2. I think my oral health is…
   a. Excellent
   b. Good

c. Poor c.

Will do almost anything to keep my natural teeth. Want to keep my teeth but have a certain budget of time and money that I am willing to spend. Don't expect to keep my natural teeth for a lifetime

Medical Questionnaire

Date _____

Patient's Name _____

Correct answers to the following questions will help Dr. Linh Nguyen treat you correctly so that there should not be an emergency. However, if an emergency does arise, this information will help insure proper treatment. Your answers are for our records only and will be considered CONFIDENTIAL.

Do you or have you ever had:

High blood pressure	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Diabetes	Yes ___ No ___	Hepatitis	Yes ___ No ___
Heart Condition	Yes ___ No ___	HIV/AIDS	Yes ___ No ___
Use Tobacco	Yes ___ No ___	Joint/valve/organ replacement	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___		

Allergies to:

Penicillin	Yes ___ No ___	Latex	Yes ___ No ___
Codeine/pain Meds	Yes ___ No ___	Jewelry/Metals	Yes ___ No ___
Local Anesthetic	Yes ___ No ___	Other _____	Yes ___ No ___

Are you under care of a physician now?

If yes, for what? _____

Are you taking any medication now whether prescription or over the counter? Yes ___ No ___

Date of last medical examination: _____

Name of Physician: _____ Phone: _____

Address: _____

Other Medical or Physical Conditions: _____

Please let us know before your appointment

You have ever had any heart disorders such as heart surgery, leaking valve, heart murmur, or an infection of the heart. You have ever had any joints replaced or organs transplanted. You were ever told to take an antibiotic before any dental appointment.

Office Financial Policy

Our office has established procedures that maintain quality care and a reasonable cost for our patients. Fees quoted are an estimate only. If a procedure proves to be more complex than anticipated, the fees are adjusted accordingly. Stated fees are honored for a period of 3 months.

Missed or Cancelled Appointments

The time you have reserved for your procedure is valuable. If for any reason you choose not to keep your scheduled appointment, we ask as a courtesy to us and other patients awaiting treatment that you advise us as soon as possible. If a patient cancels a procedure giving less than 24-hour notice during regular business hours, or fails to keep an appointment as scheduled, we will bill you for a non-refundable fee of $45.00

Your Insurance Coverage

Please note: Insurance is YOUR responsibility. If your insurance changes, let us know BEFORE your next appointment. If we have incorrect information and insurance is declined, YOU are responsible for all payment and insurance will have to reimburse you. As a courtesy, we are happy to file insurance claims on your behalf. However, insurance is an agreement between you and your insurance company to pay you certain dollars amount for dental care. Your dental bill is an agreement between you and Dr Linh Nguyen, and does not involve the insurance company, even when we file the insurance claim for you. In short, you are responsible for all charges that are not paid by your insurance carrier. Your financial obligation to this office for payment is not dependent on insurance coverage. If you have insurance, we will require your estimated share of the dental fee at the time of service. This estimated share is based on information obtained over the phone from your insurance carrier and is not a guarantee of payment by them. Payment for dental work must be made the day the work is done. The balance will then be due 45 days later, regardless of any insurance payments that are yet to be received by this office.

Credit Options

We are pleased to participate in Care Credit which can offer several payments plans with no interest to the patient. Should you be interested in financing your treatment, please feel free to ask our Financial Coordinator for more details.

My signature below indicates that I have read and/or had explained to me the above statement, that I understand it, and that I agree to abide by the conditions set forth therein.

_____	_____	_____
Patient Signature	Witness Signature	Date