

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1. If this appointment is for you start here			
Date			
Last Name	First Name	MI	
Prefers to be called			
Address			
City	State	Zip	
Home Phone No.	Fax		
Cell	Email		
Birthday	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security No.			
If this appointment is for your child start here			
Date			
Last Name	First Name	MI	
Address			
City	State	Zip	
Home Phone No.	Fax		
Birthday	Age	Male	Female
School	Grade		
Social Security No.			
2. Dental Insurance			
Primary Carrier			
Insurance Company			
Group No.			
Employer Name			
Insured's Name			
Date of Birth		Relationship to Patient	
Insured's ID No.			
Insured's Social Security No.			
3. Getting to know you			
Is another member of your family or relative a patient at our office?			
Name:		Relationship	

You were referred to us by		
Your former address		
City	State	Zip
Person to contact for emergency		
Phone number		
Address		
City	State	Zip
Closest Relative not living with you		
Phone number		
Address		
City	State	Zip
4. Account Information		
Person Financially Responsible for Account		
Name		
Relation to patient		Social Security No.
Address		
City	State	Zip
Phone No.		
You		
Name		
Occupation		
Employer's Name		
Address		City
Phone No.		Fax No.
Your Spouse		
Name		
Occupation		
Employer's Name		
Address		City
Phone No.		Fax No.

Medical History

Patient Name	
Patient Account No.	Medical Alert

Physician's Name _____ Phone () _____

Have you had any medical care within the past two years? Yes No

Describe: _____

Have you taken any medication or drugs during the past two years? Yes No

Are you currently taking any medication, drugs, pills or herbal remedies including any regular dosages of aspirin? Yes No

If yes, please list name and dosage _____

Have you ever taken prescriptions medications for weight loss(diet pills)? Yes No

If yes, did you take any of the following:(circle) Fen-Phen Redux Pondimen Other

If yes to any of the above, did you have a medical exam for heart issues? Yes No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No

Have you been a patient in the hospital within the past five years? Yes No

Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

- | | | | | | |
|-------------------------------------|-----|----|--------------------------------|-----|----|
| Heart (Surgery, Disease, Attack) | Yes | No | Tuberculosis | Yes | No |
| Chest Pain | Yes | No | Asthma | Yes | No |
| Congenital Heart Disease | Yes | No | Hay Fever/Allergy/Hives | Yes | No |
| Heart Murmur | Yes | No | Latex sensitivity | Yes | No |
| High/Low Blood Pressure | Yes | No | Sinus Trouble | Yes | No |
| Mitral Value Prolapse | Yes | No | Radiation Therapy | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chemotherapy | Yes | No |
| Rheumatic Fever | Yes | No | Tumors | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hepatitis A B C | Yes | No |
| Cortisone Medicine | Yes | No | Venereal Disease | Yes | No |
| Swollen Ankles | Yes | No | AIDS/HIV Positive | Yes | No |
| Stroke | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| Diet (Specific/Restricted) | Yes | No | Blood Transfusion | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Hemophilia | Yes | No |
| Kidney Trouble | Yes | No | Sickle Cell Disease | Yes | No |
| Ulcers | Yes | No | Bruise Easily | Yes | No |
| Diabetes | Yes | No | Liver Disease/Yellow Jaundice | Yes | No |
| Thyroid Problems | Yes | No | Neurological Disorders | Yes | No |
| Glaucoma | Yes | No | Epilepsy or Seizures | Yes | No |
| Contact Lenses | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Emphysema | Yes | No | Nervous/Anxious | Yes | No |
| Chronic Cough | Yes | No | Psychiatric/Psychological Care | Yes | No |

Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No

Have you lost or gained more than 10 pound in the past year? Yes No

Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

Women: Are you pregnant or think you could be pregnant? Yes ____Months No Nursing? Yes No

Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Dental History

Patient Name: _____	
Patient Account No. _____	Medical Alert _____

What is the reason for your visit today? _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-ray _____
 What was done at your last dental visit? _____

Previous Dentist Name _____
 Address _____ State _____ Zip _____
 Telephone () _____

How often do you have dental examinations? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 Have you ever used or are currently using topical fluoride? Yes No
 What other dental aids do you use? (Toothpicks, Interplak, Etc.) _____

Do you have any dental problems now? Yes No
 If yes, please describe _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any other lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth lose?	Yes	No
Does food tend to become caught in between teeth?	Yes	No
If yes, Where? _____		

Have you ever Had:

Orthodontic treatment	Yes	No
Oral Surgery	Yes	No
Periodontal treatment?	Yes	No
You teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so please describe, including cause: _____		

Have You Experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)	Yes	No

Do You:

Clench or grind you teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with you teeth?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Difficulty opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so what is your biggest concern? _____		

Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		

Have you ever been told to take pre-medication prior to dental treatment? Yes No
 Is there anything else about dental treatment that you would like us to know? Yes No
 If yes, please describe _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-ray, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the propose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient Signature _____

Date _____

Witness _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare.

Authorization: I authorize a family member to make or verify appointments on my behalf, as well as authorize a family member to verify and/or discuss account history information including, but not limited to treatment fees & plans, insurance claims and payment activities. I give permission to CUONG T. PHAN, DMD, PA to either manually confirm my dental/ortho appointment and /or utilize the automated confirmation system, to leave a message regarding my appointment. I also give permission to use photographs of me and/or my smile for the purpose of before & after photos and internal marketing purposes. My personal information will not be distributed or sold to any companies for other solicitation purposes.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matter about your protected health information. A copy of our Notice accompanies this consent as well as it is posted in our office. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as describes in our Notice of Privacy Practices. If we change our privacy practices, we will post the revised Notice of Privacy Practices, which will contain the changes, and you will be able to request a copy of the revised Notice at any time. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Privacy Office of Dr. Phan. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name: _____ Signature: _____

Today's Date: _____

Notice of Privacy Practices Acknowledgement: I have received a copy of this Office's Notice of Privacy Practices.

Patient Signature: _____