Ginnie I.Chen DDS
13420 Newport Ave., Suite L
Tustin, CA 92780
714-544-1391
www.chensmiles.com

Dear Patient,

We are delighted to welcome you to our practice and are pleased that you've chosen us to serve your dental needs. We are serious about providing superior dental care and proud of our dedication to our patients. Our goal is to help you feel and look you're very best through excellent dental care.

Your first appointment will take approximately one hour. Please notify our office if you have any heart conditions or recent joint replacements, as these require antibiotics prior to any dental treatment. To facilitate being seen just as soon as possible at the time of your appointment, we would appreciate it if you would complete the enclosed Patient Information Form before your arrival. Please remember to bring it with you at the time of your appointment along with any Dental Insurance cards that might apply to you or your family so we can then include this information with your records.

Dr. Chen is offering to our new patients our take home whitening tray system at $150.00 a $300.00 value, and our in office POWER whitening system at $199.00, a $400.00 value. **This discounted rate is only available on your first visit to our office**. If you are interested in taking advantage of our whitening procedure, please let us know when you come in.

If you are unable to make the appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time, if necessary. Driving directions and important forms can be found on our office website at www.chensmiles.com. In the meantime, we look forward to meeting you and serving your needs.

Thanks again for choosing our dental practice.

Sincerely,

Ginnie I. Chen DDS and Staff

GINNIE I. CHEN, D.D.S.
GENERAL DENTISTRY
13420 NEWPORT AVE., SUITE L
TUSTIN, CA 92780
714-544-1391

WELCOME

one ABOUT YOU

Today's Date: ___/___/___ File #:___

Patient Name: ___
LAST FIRST MI

What You Prefer To Be Called: ___ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ___ SS#: ___

Mailing Address: ___

___
CITY STATE ZIP

Home Phone #: (___) ___

Work Phone #: (___) ___ Ext: ___

Cell Phone #: (___) ___

E-mail Address: ___

Referred By: ___

Employer: ___ How Long? ___

Employer's Address: ___

___
CITY STATE ZIP

Occupation: ___

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ___

Do you have children? ❑ Yes ❑ No How many? ___

two INSURANCE INFO

Primary Dental Insurance

Co. Name: ___

Address: ___

___
CITY STATE ZIP

Phone #: (___) ___

Insured's ID#: ___

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

Insured's Name: ___

Relation: ___ Date of Birth: ___/___/___

Insured's Employer: ___

Secondary Dental Insurance

Co. Name: ___

Address: ___

___
CITY STATE ZIP

Phone #: (___) ___

Insured's ID#: ___

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

Insured's Name: ___

Relation: ___ Date of Birth: ___/___/___

Insured's Employer: ___

three ACCOUNT INFO

Person ultimately responsible for account

Name: ___

Relation: ___

Billing Address: ___

___
CITY STATE ZIP

SS #: ___

Drivers License #: ___

Work Phone #: (___) ___

Payment method: ❑ Cash ❑ Check

___ ___/___
❑ Credit Card - Enter card # above (if accepted)

___ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ___

Relation: ___

Home Phone #: (___) ___

Work Phone #: (___) ___

Cell Phone #: (___) ___

Who is your Medical Doctor? ___

Medical Doctor's Phone #: (___) ___

PLEASE CONTINUE ON BACK

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocain, act.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
4. How long since your full mouth x-rays_____Weeks_____Months_____Years_____
5. How long since your last Dental Treatment?_____Weeks_____Months_____Years_____
6. Does Dental Treatment make you Nervous? ☐ Slightly ☐ Moderately ☐ Extremely ..... Yes No
7. Would you desire to be pre-sedated? ..... Yes No

☐ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

☐ **Our policy reqnires payment in full services rendered at the time of visit, unless other arrangements have been made with the office** manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for the legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is me responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/____
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Ginnie I. Chen
General Dentistry
13420 Newport Avenue, Suite L
Tustin, CA 92780
Telephone: (714)544-1391

ABOUT YOUR INSURANCE BENEFITS

Benefit coverage is a contract between yourself, the insurance company and your employer, ***not the dentist.***

Dental benefits do not cover 100% of your dentistry,

We encourage our patients to know their plan, in order to eliminate Disappointments with payment and reimbursement.

In order to keep our procedure fees reasonable and provide the highest quality dental work, our office asks our patients to be responsible for all laboratory fees associated with your treatment.

Often insurance companies are sending back approvals with request for cheaper, alternative treatment plans. Our office is happy to discuss any alternatives and choices with our treatment plan prior to treatment.

Insurance benefits are estimates and there is no guarantee of payment until they receive a claim. If your insurance company pays less than expected, you as the patient are responsible for any differences they do not cover. ***Balances after 60 days become the patient's responsibility and are due in full.***

It is your responsibility to make sure your insurance is active. If at the time of service you are not eligible in our office you will be responsible for the full usual and customary fees.

Broken appointments without 24hours notice will carry a $30.00 charge. Three broken appointments without 24 hrs. Notice will force us to ask you to leave our practice.

I have read and understand my responsibility for my dental Insurance benefits.

Signature_____ Date_____

PATIENT CONSENT TO TREATMENT

Please read and initial the items checked below and read and sign the section at the bottom of form.

Patient Name_____

❑ **1. Work To Be Done**
I understand that I am having the following work done: Fillings_____Bridges___Crowns___Extractions_ Impacted teeth removed_____General Anesthesia _____Root Canal_____Other_____

(Initial_____

❑ **2. Drugs And Medications**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction

(Initial_____

❑ **3. Changes In Treatment Plan**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Initial_____

❑ **4. Fillings.**
I have been advised of the need for fillings, composites (plastics), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing material. In cases where very little tooth structure remains, or existing tooth structures fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up and crowns), which should necessitate a separate charge.

(Initial_____

❑ **5. Removal Of Teeth**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, ect.) and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **(Initial_____**

❑ **6. Crowns, Bridges And Caps**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easy and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. **Due to Crown prep procedure,I realize that permanent gingival recession can occur resulting in exposed margin of crown and possible increased Sensitivity or more extensive Treatment (Such as Root Canal Therapy Post and Build Up), which should necessitate a SEPARATE CHARGE.**

(Initials_____

❑ **7.Dentures, Complete Or Partial**
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me. Including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit size, placement, and color) Will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee

(Initials_____

❑ **8.Endodonitc Treatment (Root Canal)**
I realize there is no guarantee that will save my tooth, and that complications can occur from the treatment, and that occasionally additionally surgical procedures may be necessary following root canal treatment (apicoectomy)

(Initials_____

❑ **9.Periodontal Loss (Tissue &Bone)**
I understand that I have a serious condition, causing gum and bone infection or loss that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and\or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____

I understand that dentistry is not an exact science and that, therefore, reputable practioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. **I consent to the proposed treatment.**

Signature of Patient_____ Date_____

Signature Of Parent/Guardian if patient is a minor_____ Date_____