

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient #:

Patient Information

Title: First Name: Middle Name: Last Name: I prefer to be called:

Sex: Age: Date of Birth (mm/dd/yyyy): Social Security #: / / - -

Home Phone: Work Phone: Cell Phone: E-mail Address: - - - -

Home Address: City: State: ZIP Code:

Employment: Employer's Name: Employer's Phone: Occupation: - -

Student Status: School Name (if a full-time student):

Best places and times to contact you: Send appointment reminders via:
 Text Message Email

Please tell us where you heard about us (check all that apply):
 Friend or Relative (name):
 Insurance Company Our Website Newspaper Ad
 Ad in Mai Saw our Office Search Engine (Google, etc.) Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor): Spouse/Parent Cell Phone: - -

Other family members treated by us: What do you already know about our office? What are your expectations? What would it take for you to trust us as your dentist?

Emergency Contact

First Name: Last Name: Relationship to Patient:

Home Phone: Cell Phone: - - - -

Insurance Information

Primary Insurance

Insurance Holder's Name:		Date of Birth (mm/dd/yyyy): / /		Relationship to Patient:		Employer:	
Member ID:	Group ID:	Insurance Company Name:			Insurance Company Phone: - -		
Insured's SSN:		Insurance Company's Address:		City:		State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:		Date of Birth (mm/dd/yyyy): / /		Relationship to Patient:		Employer:	
Member ID:	Group ID:	Insurance Company Name:			Insurance Company Phone: - -		
Insured's SSN:		Insurance Company's Address:		City:		State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize True Care Dental to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to True Care Dental. I permit a copy of this authorization to be used in place of the original. I give True Care Dental, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications 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.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Payment

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance.

Would you like to discuss our office's financial policy? Yes No

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to True Care Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to True Care Dental to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

Dental History

Dental Hygiene

How often do you visit a dentist?

Do you brush your teeth? If yes, how often?

Do you floss? If yes, how often?

Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

Dental Concerns

Check all that apply.

Teeth

- | | | |
|--|--|--|
| <input type="checkbox"/> Broken or chipped | <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Sensitive to heat |
| <input type="checkbox"/> Decay | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Sensitive when biting |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Sensitive to sweets |
| <input type="checkbox"/> Tooth pain | <input type="checkbox"/> Sensitive to cold | <input type="checkbox"/> Orthodontic treatment |

Gums

- | | | | |
|---|------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Abscessed | <input type="checkbox"/> Sore | <input type="checkbox"/> Receding |
| <input type="checkbox"/> Red (discolored) | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Swollen | <input type="checkbox"/> Periodontal treatment |

Facial/Jaw Pain

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Pain in temples | <input type="checkbox"/> Jaw injury | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Avoid certain foods | <input type="checkbox"/> Jaw locks open/closed | <input type="checkbox"/> Head injury | |
| <input type="checkbox"/> Popping/clicking | <input type="checkbox"/> Pain in jaw | <input type="checkbox"/> Neck injury | |

Ratings

1 2 3 4 5

On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.

1 2 3 4 5

On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.

1 2 3 4 5

On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?

1 2 3 4 5

On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?

1 2 3 4 5

On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:

Phone:

Last Visit: /

Address:

City:

State:

ZIP Code:

Do we have permission to contact your doctor regarding your care? Yes No



Have you ever had:

Check all that apply.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells/ Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Liver Problems/ Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Hypotension/Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart attack/Failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold sore/Fever blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart trouble/disease | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Head/Neck/Face Injury | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> swollen neck glands | <input type="checkbox"/> Numbness of arms/hands |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Smoker | <input type="checkbox"/> TMD/TMJ (jaw pain) |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> History of Substance abuse | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Tattoos/Piercings |
| <input type="checkbox"/> Hospitalized any reason | <input type="checkbox"/> | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Sexually Transmitted Diseases |

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Metals | <input type="checkbox"/> LATEX | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Nirous oxide | <input type="checkbox"/> rubber sedatives |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Barbiturates (sleeping Iodine Penicillin/antibiotics Xylocaine pills) | | |

If female, please mark if you are:

- Pregnant - If so, please enter your due date or week #: _____ Nursing

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act).

I understand that True Care Dental will not use my health information for marketing communications without written authorization. And they may use or disclose health information when it is required to do so by law. True Care Dental may, also, use or disclose health information to a physician and other healthcare provider proving treatment to you.

I have read the HIPPA form that was given to me and I understand that by signing this consent, I authorize True Care Dental to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies. The day to day healthcare operations of your dental practice.
- Additionally, I authorize you to share all my protected health information with the following individual(s):

Name:	Relationship:	Phone: - -
Name:	Relationship:	Phone: - -
Name:	Relationship:	Phone: - -

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

If signing on behalf of someone, explain your relationship to the patient:

Cancellation/Reschedule Policy

We understand that unexpected events can come up and you may need to cancel or reschedule an appointment. If that happens, we request a 24-hour notice for cleaning appointments scheduled with our hygienist. There is a fee of \$20.00 for hygiene appointments that are cancelled or rescheduled with less than 24 hour notice. Any restorative procedures or any treatment in general that is scheduled with Dr. James Nguyen and Dr. Kim Nguyen will require a 48-hour notice to reschedule. There is a \$50.00 fee for procedures scheduled with Dr. James Nguyen and Dr. Kim Nguyen that are cancelled or rescheduled with less than 48 hour notice. **Any appointment cancellation due to illness will require a physician's note.** Thank you for your understanding and cooperation.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

Photo Release (OPTIONAL)

I grant permission to Dr. James Nguyen DDS and Dr. Kim Nguyen DDS to post me or my child's story, photo, or other item, hereinafter referred to as "Materials". I submit to and for Dr. James Nguyen, DDS and Dr. Kim Nguyen, DDS to use these materials for use on any of the following: True Care Dental website, Instagram account (@truecaredental_), Facebook, official office paperwork (before and after photos, brochures, flyers, etc). I hereby release you, your representative, employees, managers, members, officers, subsidiaries, and directors from all claims and demands arising out of or in connection with use of said materials, including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the materials or any rights therein. If signing for my child, I acknowledge that they are under 18 years old and lacks legal capacity to enter into binding agreements. Accordingly, I have read this release and consent to my child's inclusion in the materials, will not contest the rights granted in this release, and shall assist and support you in any and all legal proceeding for affirmation of this agreement, should you choose to have a court of law affirm this agreement.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /