



## New Patient Health and Dental History

### Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

The best time to contact me is: \_\_\_\_\_  A.M.  P.M. on my  Home phone  Work phone  Cell phone

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced

If student, name of school: \_\_\_\_\_ City/State: \_\_\_\_\_  FT  PT

Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

### Responsible Party

Relationship to Patient:  Self  Spouse  Parent  Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Insurance Information

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Ins Co Address: \_\_\_\_\_ Ins Co. Phone #: \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Ins Co Address: \_\_\_\_\_ Ins Co. Phone #: \_\_\_\_\_

*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 healthcare provider or agency, who may release such information to you. I will notify the doctor of any change in my insurance.*

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Health History

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years?  Yes  No

If yes, reason: \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving care? No Yes If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

*For the following questions, check yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Anemia or Blood Disorder	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Hepatitis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Arthritis, Rheumatism or Other Inflammatory Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Joint Replacement	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Kidney Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Abnormal Bleeding from a Cut	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Liver Disease (including Jaundice)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer or Tumor	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Sore/Enlarged Lymph Nodes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Psychosis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Emphysema or other Respiratory/Lung Illnesses	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Previous Biopsies	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Epilepsy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Radiation or Chemotherapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Fainting or Dizzy Spells	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Rheumatic Fever	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Glaucoma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Slow-Healing Mouth Sores	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Abnormal Heart or Previous Bacterial Endocarditis	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Unintentional Weight Loss/Gain	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Valve (artificial) or Heart Transplant	No <input type="checkbox"/>	Yes <input type="checkbox"/>	H.I.V. Infection/AIDS or ARC	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Congenital Heart Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Venereal Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Disease, Heart Attack, Heart Surgery	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Other Conditions	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Stent	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Recurrent Illness	No <input type="checkbox"/>	Yes <input type="checkbox"/>

### Are you taking any of these medications?

Pre-medication before dental treatment?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Antacids?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cardizem® (diltiazem) or Calan, Isoptin®(Verapamil)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Dilantin® or Tegretol® No Yes Serzone® (nefazodone)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox®(itraconazole)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If so, when did the treatment begin? _____ When did the treatment end? _____		
Have you ever taken any prescription drugs such as fen-phen for weight loss?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you consume grapefruit juice, grapefruits or grapefruit extract?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

**Please list any medications you are currently taking and dosages:**

1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_
5. \_\_\_\_\_ 6. \_\_\_\_\_
7. \_\_\_\_\_ 8. \_\_\_\_\_

**Please list any dietary or herbal supplements you are taking, and for what purpose:**

1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_
5. \_\_\_\_\_ 6. \_\_\_\_\_
7. \_\_\_\_\_ 8. \_\_\_\_\_

**Women Only:**

Are you pregnant? No  Yes

If no, are you planning a pregnancy in the near future? No  Yes

Are you a nursing mother? No  Yes

Are you taking birth control pills? No  Yes

Do you have abnormal blood pressure? No  Yes

Have you ever received a diagnosis of "high blood pressure"? No  Yes

Are you allergic or have you had a reaction to:

1. Local anesthetics No  Yes

2. Penicillin or other antibiotics No  Yes

3. Aspirin, Ibuprofen or Tylenol No  Yes

4. Codeine, Valium® or other sedatives No  Yes

5. Latex or Metals No  Yes

6. Other (please specify) \_\_\_\_\_

**Tobacco, Alcohol, Drugs**

Do you use tobacco? No  Yes   
smoke  chew  How much per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you want to quit using tobacco? No  Yes

Do you consume alcohol? No  Yes

If yes, approximately how many alcoholic beverages per week?

Do you use any mood-altering drugs other than those previously listed? No  Yes

## Dental History

When was your last dental visit?: \_\_\_\_\_ How often do you see your dentist?: \_\_\_\_\_

Are you having any dental problems that require immediate attention?: \_\_\_\_\_

Do you have frequent headaches?: \_\_\_\_\_ Ear aches?: \_\_\_\_\_ How often?: \_\_\_\_\_

Is there anything that will cause your muscles to be tired, sore or cause headaches?: \_\_\_\_\_

Are your jaw joints painful or tender?: \_\_\_\_\_ If yes, please describe?: \_\_\_\_\_

Have you had trauma to your jaw?: \_\_\_\_\_ Do your jaw joints pop, click or grate?: \_\_\_\_\_

Do your jaws ever feel tired or ache?: \_\_\_\_\_ Have you been told you have TMJ?: \_\_\_\_\_

Do you clench or grind your teeth?: \_\_\_\_\_

Does your bite feel comfortable?: \_\_\_\_\_ Have you noticed any change in your bite?: \_\_\_\_\_

Have you ever been told you have periodontal disease?: \_\_\_\_\_ Have you ever had periodontal treatment?: \_\_\_\_\_

Do your gums bleed while cleaning?: \_\_\_\_\_ Do your gums ever feel tender or swollen?: \_\_\_\_\_

How often do you brush your teeth?: \_\_\_\_\_ Floss?: \_\_\_\_\_ Water Jet?: \_\_\_\_\_

Do any of the following cause tooth discomfort?: Hot  Cold  Sweets  Chewing

Have you noticed any changes in your teeth?: \_\_\_\_\_

Do you have any of the following?: Loose teeth  Worn teeth  Broken/Chipped teeth  Food traps

Can you chew on both sides of your mouth?: \_\_\_\_\_ Comfortably?: \_\_\_\_\_

Do you lose or break fillings?: \_\_\_\_\_ Do you usually have cavities?: \_\_\_\_\_

Have you ever had orthodontic treatment?: \_\_\_\_\_ When?: \_\_\_\_\_

Do you have any missing teeth?: \_\_\_\_\_ Have they been replaced?: \_\_\_\_\_

Do you have any of the following?: Fixed bridge  Removable partial  Full dentures  Dental implants

Are you comfortable with the replacement?: \_\_\_\_\_ Please describe: \_\_\_\_\_

How do you feel about the appearance of your smile?: \_\_\_\_\_

What improvements would you like to make in your mouth?: \_\_\_\_\_

Please add anything else you feel is important?: \_\_\_\_\_

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\_\_\_\_\_  
Patient/Guardian (Print Name)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor (Print Name)

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date



## Patient Financial Agreement

*At Creating Smiles it is our philosophy to provide outstanding care to patients who expect the very best and to educate them to become partners in their own dental health.*

In an effort to keep fees reasonable and to continue to provide quality care, we have established a payment policy.

Our office will be happy to bill your insurance carrier; however, we do require payment of any uncovered services, deductibles or co-payments to be taken care of at each appointment.

1. All routine dental treatment will be paid in full at the time the treatment is rendered.
2. Cash, check, Visa or MasterCard are all acceptable forms of payment.
3. We have an office manager who will be happy to help you with your individual needs. For treatment plans you will be given an **ESTIMATE** of what your insurance company will pay, and any co-payment will be handled according to the above financial policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Our office cannot negotiate with your insurance company for reimbursement of dental expenses. If your insurance does not pay in full within 60 days, we ask that you contact them, as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a \$35.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of the collection and/or legal fees. Collection costs are calculated by adding to the principal the amount of \$25.00.
4. In the event of a missed appointment without 24 hours notice, a \$50.00 broken appointment fee will be assessed.

### Deposit Policy

For some procedures a deposit may be required to reserve the appointment time. In the event of a missed appointment without 24 hours notice, a **NON-REFUNDABLE** penalty will be assessed at the rate of \$100.00 per hour. This will be deducted for the appointment deposit and **WILL NOT** be re-applied to that or any other treatment fee. The patient will then be responsible for the full fee at the time of service.

I have read and understand the financial policy outlined above.

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Patient/Guardian (Print Name)

Patient/Guardian Signature

Date



## Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary reason that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors. Studies also suggest that human papilloma virus (HPV 16/18) plays a role in more than 29% of oral cancer cases. Oral cancer risk by patient profile is as follows:

- **Increased Risk:** Sexually active patients age 18-39 (HPV 16/18).
- **High Risk:** Patients age 40 and older; tobacco user, age 18-39, any type within 10 years.
- **Highest Risk:** Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer.

We have incorporated ViziLite Plus into our oral screening and standard of care. We find that using ViziLite Plus along with our standard oral cancer examination improves that ability to identify suspicious areas at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. This ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is \$65.00.

I accept the ViziLite Plus exam  I decline the ViziLite Plus exam

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*Patient/Guardian (Print Name)*

*Patient/Guardian Signature*

*Date*



## Office Policies

The staff here at Creating Smiles is committed to providing outstanding dentistry. By consenting to the treatment recommended by the dentist you are helping us to maintain that extraordinary level of care.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital on any possible complications.

I understand a treatment option is to receive no treatment. I also understand that I have a right to refuse any treatment Dr. Nguyen recommends by signing a separate refusal of treatment consent form consisting of risks of no treatment. I further understand that unwillingness to sign a refusal of treatment form or refusal of multiple recommended treatments could lead to dismissal from Dr. Nguyen's care.

I understand that during the course of treatment, conditions not evident during examination may necessitate procedures different from those planned and my need a specialist for necessary treatment. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that waiting on treatment needed may compromise the treatment initially proposed, which may necessitate more extensive treatment or procedures.

I hereby give Dr. Nguyen the absolute right and permission to use my photographs/slides for education or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of the said photographs/slides.

I understand that my treatment cannot be discussed outside of my presence to anyone, unless written notification is given to the office manager. This is to ensure privacy and the dignity of all involved, as well as obeying HIPPA regulations. If at any time I use profanity or threatening language toward the office staff in an offending manner, I understand I can be dismissed from care. The office phone number is for true dental emergencies, and my call will be returned within a reasonable time frame.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

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*Patient/Guardian (Print Name)*

*Patient/Guardian Signature*

*Date*



## Notice of Privacy Practices (HIPAA)

The following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.**

You have the right to do this under federal law; however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law and prohibits access to protected health information.

2. **You have the right to request a restriction of your protected health information.**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We will not release any information without your written consent.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another dental professional.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have a right to obtain a paper copy of this notice from us; upon your request you have agreed to accept this notice alternatively, i.e., electronically.

4. **You may have the right to have your dentist amend your protected health information.**

If we deny your request for amendment, you have a right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. **You have the right to change the terms of this notice and will inform you by mail of any changes.** You then have the right to object or withdraw as provided in this notice.

### Complaints:

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide, individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please inform the staff.

Your signature below is an acknowledgement that you have received this Notice of Privacy Practices.

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*Patient/ Guardian (Print Name)*

*Patient/ Guardian Signature*

*Date*