

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out these forms completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

PATIENT INFORMATION

Name (Last, First): _____

Date of Birth: _____ SSN: _____ Driver's License _____

Sex: M F Status: Single Married Minor Divorced Widowed

Address: _____ City _____ State _____ Zip _____

Cell: _____ Home: _____ Work: _____

Email: _____

INSURANCE INFORMATION

Occupation: _____ Employer: _____ Work Hours: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Insurance Company: _____ Member's SSN: _____

Member ID: _____ Group #: _____

Relationship to patient: _____

EMERGENCY CONTACT

Name: _____ Cell: _____ Relationship: _____

REFERRAL INFORMATION

How did you hear about us?

Family _____ Friend _____ Coworker _____
 Signs Insurance Yelp Website Other _____

DENTAL CONCERNS

What are your present dental problems? _____

When was your last dental appointment? _____

Why did you leave your last dentist? _____

Are your teeth sensitive to sweets, hot/cold, or biting pressure? Y N

Does dental treatment make you nervous? no slightly moderately very

I think my dental health is... excellent good fair poor

If I could change my smile, I would make my teeth...

whiter straighter close spaces repair chips

I have received a copy of the Notice of Privacy Practices and Dental Materials Fact Sheet.

(Initial _____)

HQNguyen Dental

MEDICAL HISTORY

Patient Name _____ Date of birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Have you ever had a serious head or neck surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Are you taking any medications, pills or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or any medications that contain bisphosphonates (medications to treat osteoporosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____
Do you, or did you, use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____

Women: Are you...
 Pregnant/ Trying to get pregnant? Nursing Taking Oral Contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin/Amoxicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Local Anesthetics

Other? If yes, please list _____

Do you have, or have you had, any of the following conditions:

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

Have you ever had any serious illness not listed? Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. 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

Signature of Patient/ Parent/ Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

DENTAL TREATMENT CONSENT FORM

Patient Name _____ Date of birth _____

Please read and initial the items checked below and sign at the bottom of the page

1. WORK TO BE DONE

I understand that I am having the following work done: Exam/Xrays ___ Fillings ___ Crowns/ Bridges ___ Extractions ___ General Anesthesia ___ Root Canal ___ Other _____ (Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions, including redness, swelling of tissues, pain, itching, vomiting, and/ or anaphylactic shock (severe allergic reactions) (Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatments 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 (Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) 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 the infection, if present, and it may be necessary to have further treatment. I understand the risks 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 the following treatment, the cost of which is my responsibility. (Initials _____)

5. CROWN, BRIDGES

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 easily 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, (including shape, fit, size, and color) will be before cementation. (Initials _____)

6. 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 refining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone Inflammation or loss and 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 practitioners 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 _____

AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL PATIENT RECORDS

Patient Name: _____ Patient date of birth: _____

I authorize HQNguyen Dental Corp. to release identifying health information under the following terms and conditions:

1. Care and services rendered at HQNguyen Dental Corp. including but not limited to progress notes, treatment plans, radiographs, treatment, and follow-up care recommendations.
2. To the referring dentist(s):
3. To your dental insurance carrier in order to process any claims (if applicable):
4. The purpose of this release is to coordinate and communicate patient care between HQNguyen Dental Corp. and the aforementioned parties.
5. If no expiration date is specified, this release will expire one year from the signature date.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it at a later date. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you would like to revoke your authorization, please send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as they wish. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THIS DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____

Print name: _____