PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ______________________ Date of birth: __________ Sex: ______ Age: ______

Home address: ______________________ City: __________ State: ______ Zip: __________

Billing address (if different): ______________________ City: __________ State: ______ Zip: __________

Home phone: __________ Cell: __________ E-mail: __________ Driver's license #: __________ State: ______

SS #: __________ Employer/Occupation: __________ Bus. Phone: __________

Spouse's name & phone #: ______________________ Emergency phone # (other than spouse): __________

Primary dental insurance: ______________________ Group #: __________

Secondary dental insurance: ______________________ Group #: __________

Subscriber's name: ______________________ Date of birth: __________ SS #: __________

Name of your medical doctor: ______________________ Date of last visit to medical doctor: __________

Name of previous dentist: ______________________ Date of last visit to dentist: __________

Referred to us by: ______________________

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? ______________		
How often do you floss? ______________		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other ______		

Notes: ______________________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ______		
Do you smoke?	☐	☐
If so, how much? ______		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ______________________

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other ______		

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ______		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ______		

Notes: ______________________

Patient/Parent Signature: ______________________

The completion of this form is optional for patients 18 years or older.

MUST BE COMPLETED FOR MINORS.

I, ______________________________ give ____________________________________

(patient) (spouse, family member, friend, etc.)

permission to discuss my dental account which includes treatment, balances, appointments, etc. with the office listed below and its employees, unless written notification is given otherwise:

Ashley S. Nguyen, D.D.S.
901 N. Washington Street
Suite 202
Alexandria, VA 22314
(703)706-9564

____

Signature

____

Print Name

____

Date

Scanned copy serves as original

Ashley S. Nguyen, DDS, PLLC

901 North Washington Street, # 202
Alexandria, VA 22314
703-706-9564

SIGNATURE ON FILE

Please initial or check for possible changes in insurance coverage or eligibility.

_____ I authorize use of this form on all my insurance submissions.*

_____ I authorize release of pertinent information to all my insurance companies.*

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.*

_____ I authorize payment direct to my doctor.*

_____ I understand that I am ultimately responsible for my bill.*

_____ I permit a copy of this authorization to be used in place of the original.*

Print Name: ______________________ SS# ________________________

Signature: ________________________ Date: ______________________

Acknowledgement/Consent Form of Privacy Practice

I have received the Notice of Privacy Practices and 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 your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as listed.

Please Print Patient Name

Patient/ Guardian Signature

Date

* SCANNED COPY SERVES AS ORIGINAL *

Dr. Ashley S. Nguyen, DDS, PLLC.
Cosmetic and General Dentistry
901 N. Washington Street, #202
Alexandria, VA 22314

Office Policies

Effective January 1, 2011

Fees and Payments

Fees- Payment for service must be made by on the following options.

Per Appointment- If you are not covered by an insurance plan, full payment is due at the time of service. We accept cash, check, Visa, MasterCard, and Discover. Please note there will be a fee of $25.00 for returned checks.

Co-payment- We will **ESTIMATE** your co-payment based on information provided by your carrier. **Co-payment is due at the time of your visit.**

You must understand that **YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER AND NOT BETWEEN THE INSURANCE CARRIER AND THE DOCTOR. YOU ARE FULLY RESPONSIBLE FOR ALL DENTAL FEES, EVEN IF YOUR CARRIER DENIES OR EXCLUDES COVERAGE.**
Insurance Assignment-Our office will submit to your insurance company for services rendered at the time of your visit.

Cancellations and Missed Appointment Charges

Broken appointments are not fair to any of the parties involved. They deny other patients the use of this time. They cost the practice money as staff salaries and other expenses continue. They make our office hesitant to appoint that patient again. Our practice does not profit from these charges. We merely cover expenses for our time that was set aside for you. In order to recoup and recover expenses incurred by broken appointments, we charge

$60.00 per hour. These charges are assessed to patients that have not given our office 24-48 hours "business day" notice.

Interest and Late Charges

Interest-Interest will be charged at a rate of 1.5% per month on the current amount due. Interest is not charged on amounts due from your insurance carrier.

Late Charges-When current patient balance due is not paid by the due date, late fees and interest **are** added to the account.

Please be aware that your account with our office is not a revolving credit line. We assist with insurance as a courtesy only. All fees are due upon demand. In the event of any and all disputes with the insurance carrier, fees must be paid to our office. You are responsible for disputing insurance company liability directly with your carrier. Our office will provide documentation only.

Transfer of Patient Records

Your request to transfer your dental records should be submitted in writing or by e-mail. We will copy your current x-rays and mail or e-mail* them to a dentist of your choice for a fee of $25.00 per individual; *we will e-mail at no charge.

By your signature, it is understood and agreed that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside the office to any agency for the collection of fees, you will be charged for the additional expenses.

X ____
(Patient Name)

X ____
(Patient/Guarantor Signature)

Date: ________________