

# Patient Information Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

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

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

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

Sex  Male  Female    Marital Status  Married  Single  Divorced  Separated  Widowed

In case of emergency, who should be notified? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Is the patient a Minor?  Yes  No    Full-time Student  Yes  No    Name of School \_\_\_\_\_

Name of Responsible Party: First \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient  Self  Spouse  Parent  Other \_\_\_\_\_

If patient is a Minor, primary residency  Both Parents  Mom  Dad  Step Parent  Shared Custody  Guardian

Address: (if different from patient) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work Mobile \_\_\_\_\_

Employer (if different from above) \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

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

## Dental Benefit Plan Information

Primary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Secondary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

# Medical Plan Information

Plan Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_  
Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_ Deductible Amount \_\_\_\_\_

## Whom may we thank for referring you?

- One of our valued patients (name of patient) \_\_\_\_\_  
 Advertisement \_\_\_\_\_  Local Dental Society \_\_\_\_\_  
 Our Website \_\_\_\_\_  Other \_\_\_\_\_

## Please list other members of your immediate family who are patients in our practice

\_\_\_\_\_  
\_\_\_\_\_

**Patient Responsibilities:** We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment \_\_\_\_\_ *\*Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

**Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

**Scheduling of Appointments:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$ \_\_\_\_\_ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$ \_\_\_\_\_ or deposit to reserve the appointment time again, may be required.

**Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

- I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is \_\_\_\_\_  
 I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is \_\_\_\_\_  
 I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

**Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. \_\_\_\_\_(initial)

I have read the above and agree to the financial and scheduling terms. \_\_\_\_\_(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.  
YES / NO (Circle One) \_\_\_\_\_(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. \_\_\_\_\_(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. \_\_\_\_\_(initial)

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Confidential Health History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?  
If NO, explain: \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain: \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain: \_\_\_\_\_
4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam: \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain: \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_
6. Yes / No Are you in pain now?  
If YES, explain: \_\_\_\_\_

## II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |
- Other: \_\_\_\_\_

## III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |  |  |                                     |
|--|--|-------------------------------------|
| Yes / No Heart disease                   | Yes / No AIDS/HIV                        | Yes / No Psychiatric care           |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis               |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease            |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                     |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                  |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                     |
| Yes / No Rheumatic fever                 | Yes / No Radiation                       | Yes / No Canker or cold sores       |
| Yes / No Skin disease                    | Yes / No Arthritis, rheumatism           | Yes / No Anemia                     |
| Yes / No Hardening of arteries           | Yes / No Emphysema or other lung disease | Yes / No Liver disease              |
| Yes / No High blood pressure             | Yes / No Kidney or bladder disease       | Yes / No Eye disease                |
| Yes / No Seizures                        | Yes / No Stroke                          | Yes / No Transplants                |
| Yes / No Cosmetic surgery                | Yes / No Eating disorders                | Yes / No Tuberculosis               |
- Other: \_\_\_\_\_

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**

(Please circle Yes or No for each)

- |  |                                    |                                     |
|--|------------------------------------|-------------------------------------|
| Yes / No Aspirin                         | Yes / No Valium or other sedatives | Yes / No Codeine or other narcotics |
| Yes / No Penicillin or other antibiotics | Yes / No Latex                     | Yes / No Food                       |
| Yes / No Nitrous oxide                   | Yes / No Local anesthetic          | Yes / No Metal                      |
- Others: \_\_\_\_\_

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**

(Please circle Yes or No for each)

- |                                     |                                   |                      |
|-------------------------------------|-----------------------------------|----------------------|
| Yes / No Recreational drugs         | Yes / No Tobacco in any form      | Yes / No Antibiotics |
| Yes / No Over-the-counter medicines | Yes / No Alcohol                  | Yes / No Supplements |
| Yes / No Weight loss medications    | Yes / No Bisphosphonate (Fosamax) | Yes / No Aspirin     |
| Yes / No Anti-Depressants           | Yes / No Herbal Supplements       |                      |
- Please list all prescription medications: \_\_\_\_\_

**VI. WOMEN ONLY** (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If YES, what month? \_\_\_\_\_
- Yes / No Are you nursing?
- Yes / No Are you taking birth control pills?

**VII. ALL PATIENTS** (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?  
If YES, please explain: \_\_\_\_\_
- Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: \_\_\_\_\_
- Yes / No Have you ever taken Fen-Phen? If YES, when: \_\_\_\_\_
- Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Whom would you like us to contact in case of an emergency?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)      Date      \_\_\_\_\_  
Signature of Dentist      Date

# DENTAL TREATMENT CONSENT FORM

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 Canals \_\_\_\_\_ Other exam. waxes \_\_\_\_\_  
\_\_\_\_\_  
(Initials \_\_\_\_\_)

**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).  
\_\_\_\_\_  
(Initials \_\_\_\_\_)

**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.  
\_\_\_\_\_  
(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 following treatment, the cost of which is my responsibility.  
\_\_\_\_\_  
(Initials \_\_\_\_\_)

**5. CROWN, 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 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, or cap (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 relining 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 infection 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 \_\_\_\_\_

# Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign This Acknowledgement*

I, \_\_\_\_\_ [full name], have received a copy of the Jeffrey R. Wong, D.D.S.  
Notice of Privacy Practices.

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

**Personal Representative's name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

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## For Program Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)