Patient Information Form

Dr. ☐
Mr. ☐
Mrs. ☐
Ms.☐ _____ Name you like to go by? _____
Address _____ City_____ Zip _____ Phone _____
Age _____ Birth Date _____ Marital Status S M W D Sep. Reason for this visit _____
Cell phone _____ Email _____ ☐ I would like to receive correspondence via Email.
Social Security # _____ Driver's License # _____ State _____
Patient Employed By _____ Occupation _____ How Long? _____
Bus. Address _____ City _____ Zip _____ Phone _____
Name of Spouse _____ Employed By _____ Occupation _____ How Long? _____
Bus. Address _____ City _____ Zip _____ Phone _____
Name of nearest relative not living with you _____ Relationship _____
Address _____ City _____ Zip _____ Phone _____
Name of Dentist _____ How Long? _____ City _____
Name of Physician _____ How Long? _____ City _____
Whom may we thank for recommending us to you? _____

HEALTH HISTORY

Periodontal disease is often the result of many factors. Successful treatment may depend on resolution of these factors.

	Yes or No		Please Explain
1. Are you in good health? → → →		If no,	
2. Date of last physical examination _____ 20 _____			
3. Are you being treated by a physician now?		If yes,	
4. Are you taking any drugs, herbs, supplements or medication?		If yes,	
5. Have you had excessive bleeding requiring special treatment?		If yes,	
6. Have you had surgery/been hospitalized?		If yes,	
7. Are you having pain in your mouth now?		If yes,	
8. Have you ever had periodontal treatment?		If yes,	
9. Do you have any concerns about your smile?		If yes,	
10. Do you feel anxious about dental treatment?		If yes,	
11. Do you clench or grind your teeth?		If yes,	
12. Do you have frequent headaches or neck aches?		If yes,	
13. Have you ever had psychiatric treatment?			
14. Have you ever taken medications for osteoporosis/osteopenia		If yes,	

15. Have you ever had any of the following conditions? Please answer Yes or No.

	Yes/No		Yes/No		Yes/No
RHEUMATIC FEVER		ARTHRITIS OR PHYSICAL HANDICAP		ANEMIA	
HEART DISEASE / MURMUR		BLOOD OR IMMUNE DISORDER		ASTHMA	
MITRAL VALVE PROLAPSE		LIVER DISORDER (HEPATITIS) OR JAUNDICE		GLAUCOMA	
STROKE		KIDNEY DISORDER		SINUS TROUBLE	
HIGH OR LOW BLOOD PRESSURE		RESPIRATORY DISORDER (TUBERCULOSIS)		OTHER	
DIABETES		ARTIFICIAL JOINTS OR IMPLANTS		DO YOU SMOKE?	
EYE OR RETINAL DISORDER		OSTEOPOROSIS		CONTROLLED SUBSTANCE USE?	

17. Are you allergic to any of the following? Please answer Yes, No or NE (No experience)

	Yes/No/NE		Yes/No/NE		Yes/No/NE
LOCAL ANESTHETICS ("Novocaine")		OTHER ANTIBIOTICS		ASPIRIN	
PENICILLIN		BARBITURATES, SEDATIVES, SLEEPING PILLS		CODEINE	
CHLORHEXIDINE		LATEX		OTHER DRUGS	

18. Women: Please answer Yes or No.
Are you pregnant? _____ Are you taking an anti-pregnancy drug? _____
Are you presently in menopause? _____ Are you post menopause? _____

I agree to the use of a local anesthetic, premedication and/or sedation given intravenously, orally or by inhalation upon the judgement and advice of the dentist treating me.
The answers given to this questionnaire are true and complete to the best of my knowledge.

Signature _____ Date _____

Please Complete information on back of form.

INSURANCE INFORMATION

Employee/Subscriber's name _____

Employee/Subscriber's social security number _____ Birth date _____

Patient's relationship to insured (_____child) (_____spouse) (_____self) (____other)

Name of insurance company_____

Address _____Member I.D. #_____

Group number _____Union # _____

Employer _____

Address _____ City/State_____Zip _____

Is patient a student? _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO ALL DENTAL CLAIMS

_____
SIGNED (PATIENT OR PARENT, IF PATIENT IS A MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO SHARON PHAMDUONG DDS, MS, INC.

_____
SIGNED (INSURED) DATE

If patient is covered by more than one Insurance company, please complete additional information

Patient's relationship to insured (_____child) (_____spouse) (_____self) (_____other)

Name of insurance_____ Address_____

Employee/Subscriber's name _____Payroll or employee # _____

Employee/Subscriber's social security number _____Birth date _____

Employer _____Address _____

City/State _____Zip _____

TRUTH IN LENDING

In compliance with the Federal Consumer Credit-Protection Act, we wish to notify you of our policies regarding payment for services rendered on your behalf:

• We will furnish you a monthly statement of your account showing the amounts billed and credited to you by us for the month, together with a breakdown of the length of time amounts have been outstanding on your account.

• All accounts are due and payable at the time services are rendered. If insurance benefits are available, we will gladly assist you in filing a claim. We can not accept the responsibility for collection of your insurance benefits; therefore, you are responsible for payment of your account within the time limits stated herein, regardless of the status of your insurance claim.

• I agree to pay all costs of collection by this office of any amount due, including actual attorney's fees incurred, regardless of whether or not a
lawsuit is filed. In addition, in the event that this office brings any legal action to collect on an unpaid invoice and this office prevails, you agree that you will pay this office its actual attorney's fees and other costs incurred as a result of the action.

• If payment of any charge is delayed beyond 90 days, we reserve the right to impose a FINANCE CHARGE on such amounts remaining outstanding. The FINANCE CHARGE will be computed at a PERIODIC RATE of:

11/2 percent per month, which is an ANNUAL PERCENTAGE RATE OF 18 percent.

APPOINTMENTS

At least one full business day's notice must be given if cancellation is absolutely necessary, otherwise a cancellation fee of $30 per ½ hour of appointment time will be charged. One week's notice of cancellation is required for surgical appointments. Less than one full week's notice may result in cancellation fees of up to one-half of the surgical fee. (Fees are subject to change without notice.)

I have read, understand and agree to the above policies.

SIGN HERE_____Date_____