TRANG T. LE, D.D.S., Ltd.

Family, Cosmetic, & Implant Dentistry

Patient Medical and Dental History

Patient Name: ____ Date:___________________

Although dental personal primarily treat dental conditions, your mouth is part of your entire body. Health problems you may or may not have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary Reason for Appointment: ☐Exam ☐Emergency ☐Consultation

Do you have a specific dental problem? (Please Explain):____

Do you think you have active decay or gum disease? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Do you want to keep your remaining teeth? ☐Yes ☐No

Do you have clicking, popping, or discomfort? ☐Yes ☐No

Preferred Dentist or Provider: ____

Medical History:

Are you under the care of a physician? ☐Yes ☐No If yes, please explain:________________

Have you ever been hospitalized or had a major operation?☐Yes ☐No If yes, please explain:________________

Do you use tobacco? ☐Yes ☐No If yes, check one: ☐Smoke ☐Chew

Are you taking any medications, pills, or drugs? Please List:____

Women (Are you)? ☐Pregnant ☐Nursing ☐Taking Oral Contraceptives

Are you ALLERGIC to any of the following?

☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics

☐Others: (Please be Specific) ____

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

☐Angina	☐Emphysema	☐Recent Weight Loss
☐Heart Attack	☐Lung Disease	☐Eating Disorder
☐Heart Murmur	☐Tuberculosis	☐Diabetes
☐Mitral Valve Relapse	☐Hay Fever	☐Hypoglycemia
☐Congenital Heart Disorder	☐Sinus Trouble	☐Excessive Thirst
☐Pace Maker	☐Frequent Headaches	☐Kidney Problems
☐Chest Pains	☐Stroke	☐Renal Dialysis
☐Irregular Heartbeat	☐Fainting spells/Dizziness	☐Cancer
☐Artificial Heart Valve	☐Epilepsy/Seizures	☐Chemotherapy
☐High Blood Pressure	☐Alzheimer's	☐Radiation Therapy
☐Low Blood Pressure	☐Glaucoma	☐Leukemia
☐Excessive Bleeding	☐Arthritis	☐Liver Disease
☐Bruise Easily	☐Gout	☐Hepatitis A, B, or C
☐Rheumatic Fever	☐Artificial Joint	☐Drug Addiction
☐Hemophilia	☐Swelling of the Limbs	☐AIDS/HIV
☐Anemia	☐Cortisone Medication	☐Venereal Disease
☐Scarlet Fever	☐Ulcers	☐Shingles
☐Asthma	☐Frequent Diarrhea	☐Psychiatric Care
☐Easily Winded	☐Gastric Reflux Disease	☐Osteoporosis

Have you has any other illnesses not listed above? If yes, please list: ___________________________________

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Emergency Contact: ________________________ Relationship:_____________ Phone Number:_________________

Emergency Contact: ________________________ Relationship:_____________ Phone Number:_________________

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform my dental care provider of any changes in my medical status in a timely manner.

Signature: ________________________________ Date: ___________________

TRANG T. LE, D.D.S., Ltd.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

*Obtaining payment from third party payers (E.g. my insurance company)

*The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. On the laminated sheet posted in our waiting room, we have provided a description of our policies. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how much protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ______________________________ Date of Birth: ____________________

Signature: ______________________________________ Date: ____________________________

Relationship to Patient: ___________________________

Please list any dependent family members also covered by this acknowledgement:

____

TRANG T. LE, D.D.S., Ltd.

Family, Cosmetic, & Implant Dentistry

Patient Registration Form

Thank you for selecting our dental health team! We strive to provide you with the best possible dental care. To help us meet all your oral health care needs, please fill out the following forms, present your **insurance card** to the front desk, and ask us any questions you have should you need assistance filling out your forms.

Patient Information:

Name: ____ Date: _______________________

Address: ____

City: _______________________________ State:_______ ZIP: _____________________

SSN: _______________ Driver's License Number: _______________________

Date of Birth: _______________________ Gender: ☐M ☐F

Marital Status (Check one): ☐Single ☐Married ☐Divorced ☐Widowed

Home Phone: _____________ Work Phone: ____________ Cell Phone: _____________

Caretaker/Other Phone (Specify if "Other"): ______________________________________

Email: ____

Name of Responsible Party for Account: _______________________________________

Responsible Party Status: ☐Patient ☐Spouse ☐Parent/Guardian ☐Other: __________

Primary Dental Insurance Information:

Name of Insured: ____________________________ Relationship:____________________

Insured's Date of Birth: ______________________ SSN: __________________________

Dental Insurance Company: _________________ Insurance Phone: __________________

Insurance C.O. Address: ____

Subscriber Number: ____________________ Group Number: ______________________

Employer Name: ____

Do you have secondary insurance? ☐Yes ☐No (If yes, please provide info below)

Secondary Dental Coverages:

Name of Insured: ____________________________ Relationship:____________________

Insured's Date of Birth: ______________________ SSN: __________________________

Dental Insurance Company: _________________ Insurance Phone: __________________

Insurance C.O. Address: ____

Subscriber Number: ____________________ Group Number: ______________________

Employer Name: ____

TRANG T. LE, D.D.S., Ltd.

Family, Cosmetic, & Implant Dentistry

Patient Registration Form

Children under the age of 16 must be accompanied by an adult (guardian); 16 to 18 year olds must have guardian's written consent for treatment.

I acknowledge that I am responsible for all insurance co-payments on the day of service including services performed that are not covered by my insurance provider. As a courtesy, Dr. Le's office will submit dental insurance claims and accepts no responsibility for the amount, for the amount, length, or scope of my provider's coverage. Should situations arise concerning my dental coverage, I understand it is my responsibility to contact my insurance company. If Dr. Trang T. Le is not a preferred provider for my insurance, I understand I may be responsible for payment in full the day of appointment; (In this case I will be directly reimbursed by my insurance company). Insurance coverage estimates provided to me by Dr. Trang T. Le's office are based on amounts reported by my insurance company at the time of coverage information was requested and are subject to change.

Financial Responsibility: I agree to pay all finances charges, collection costs, attorney fees, and any other costs incurred to enforce the collection of any outstanding amount.

My signature below indicates I understand and agree to all the above.

Signature: __________________________ Date: ____________________

Office Policies

Thank you for choosing the office of Trang T. Le, D.D.S., Ltd. for your dental care. We are committed to providing you with the best treatment and services available. To help us serve you, please take a moment to READ our office policy, SIGN and DATE below. If you have any questions or concerns, we will be glad to assist you.

Appointments: Please understand that once you make an appointment, that time is reserved for you. When an appointment is cancelled with less than a 48 hour notice or if the appointment is not honored, we reserve the right to charge a $50.00 fee for a missed appointment. In the event of unusual circumstances, exceptions will be made.

Financial: For patients without insurance, payment is expected when services are rendered, unless other financial arrangements have been made. If a Pre-Authorization has been received from your insurance company, payment is expected at the time of service. We accept VISA, MasterCard, American Express, Discover, checks and cash. There will be a $30.00 fee for each Returned Check or Insufficient Funds.

Insurance: Dr. Le currently participates with the Cigna Dental Savings Plan. **We will submit claims to all insurance companies.** Please keep in mind that reimbursement and dental coverage varies with in-network and out-of-network providers. Insurance policies are arrangements between you and your carrier. You are responsible for any payment not covered by your insurance. We recommend that you be familiar with your insurance policies so that we can help you obtain the maximum benefits.

Once insurance claims are processed, payment of the remaining balance is due upon receipt of Statement of Account. Past due accounts may be forwarded to a collection agency. Patients would be responsible for any collection costs.

Thank you for your cooperation and entrusting your dental health with us.

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I, ______________________________ have READ and RECEIVED a copy of the OFFICE POLICIES of Trang T. Le, D.D.S., Ltd. and agree to comply with the provisions.

Signature: ______________________________ Date: ________________