Fresno Pro Dental

Dr. Nguyen & Dr. Le D.D.S

237 W. Shields Ave.
Fresno CA 93705
(559) 227-4120

PATIENT INFORMATION

Date: ________________ Home Phone (____) __________________ Cell Phone (____) ________________________

Name____ Birth Date ______________ Soc Sec # ____________________
Last Name First Name

Address ____ E-Mail___________________________________

City ______________________________ State _____________ Zip_____________ Female _____Male ___________

Married ____Single _____Widowed ____Minor ____Separated ___Partnered ____Divorced ____

Patient Employer/School___________________________________ Occupation ______________________________

Employer/School Address __________________________________ Employer/School Phone#____________________

Whom may we thank for referring you?____

In case of an emergency who should be notified? _________________________Phone(___)___________________

PRIMARY INSURANCE

Person Responsible for Account____
Last Name First Name Middle initial

Relation to Patient_______________________ Birth date _________________ Soc. Sec. #______________________

Address (if different from patient's)_______________________________ Phone (___)___________________________

City____ State ________________Zip_____________________________

Person Responsible Employed By _____________________________ Occupation ____________________________

Business Address ____ Business Phone (___)______________________

Insurance Company ____

Contract # _________________________________ Group #_________ Subscriber # ___________________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? YES___ No ___

Subscriber Name _______________________ Birth date ____________Relationship to Pt ____________________

Address (If different from patients) _______________________________ Phone (___)__________________________

City ____ State ________________ Zip ___________________________

Subscriber Employed by _____________________________ Business Phone (___)_______________________________

Insurance Company _________________________________ Soc. Sec # ___________________________________

Contract # _________________________________ Group #__________ Subscriber #_____________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with ___________________________ and assign directly to **Dr. Nguyen & Dr. Le Fresno Pro Dental** all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Ins. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete.

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Signature of Patient, Parent, Guardian Date

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication 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? ◯ Yes ◯ No If yes, please explain: ______________________

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

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ______________________

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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, or GUARDIAN ______________________ DATE ______________

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237 W. Shields Ave Fresno CA. 93705 (559)227-4120

Financial Policy

The following policy is enforced by this office. Please read carefully and make sure that you understand the following which applies to you before signing below.

INSURANCE PLANS: As a courtesy to our patients, at your dental visits, our office will verify your insurance coverage, give you an estimate of your insurance benefits. As a courtesy, we will also bill your insurance company for you. It is the patient's responsibility to supply us with the appropriate billing information. This includes current insurance company phone number, billing address, and any other information that is required in order to receive payment. You will be responsible for the full amount of our changes and we will collect the estimated co-insurance, co-payment, deductable, or non-covered benefits on the date of service. If there is any difference between the estimated amount received from the insurance company, you will receive either a refund or a bill for any further amounts owed.

CASH SERVICES: ***Payment in full is expected at the time of service.*** In order to keep our expenses down and offer the best care available, we are unable to provide in house financing. However we do offer payment plans that are available through an outside credit company. Please see any front office staff for information.

RETURNED CHECKS: If your check is returned unpaid, you will be charged $25.00. The amount of the check and the service charge is to be paid immediately.

SHORT NOTICE CANCELLATION/MISSED APPOINTMENT: There is a $25.00 fee charged to ALL appointments not given a 24 hour notice of cancellation.

I understand that any unpaid balance after 90 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection agency.

I have read the above financial policy and understand my obligations as described.

______________________________ Signature

____________________ Date

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INFORMATION ABOUT INSURANCE

Dear Patient:

We are pleased that you have selected our office for your dental treatment. The following information is to help eliminate any questions you might have prior to your dental treatment. Please feel free to ask for an estimate prior to the treatment being performed.

Patient Health Benefit Plans (both medical and dental) are made available to employees or members through companies, Unions and associations and may **vary considerably** from one plan to the next Insurance companies must place limitations on benefits so that they can "Package a Program" for a given price.

The range of benefits depends solely on what the purchaser (employer) wished to offer employees or members. Some plans cover as little as 30% or as much as 100% of covered services with most falling in the 50% to 80% range. Some plans **exclude** certain types of services (i.e.: splints, TMJ, general anesthesia, orthodontics procedures, implants) while other plans will cover a more complete range of dental health care services.

Some insurance plans base the amount of benefits on a chart or schedule of fees arbitrarily developed by insurance companies. For this reason, **you may receive a lower percentage of the reimbursement level indicated on your plan.** For example, if your plan states that it will pay 80% of the cost of treatment, they mean 80% of the fee arbitrarily determined by the insurance company, not the actual fee charged by your doctor. Many policies have failed to increase benefits with the increase benefits with the increasing inflation. They may also fail to benefit new kinds of therapies.

As a courtesy to our patients, our office will correspond with your insurance company by phone for coverage and benefits information which we use to give you an **estimate** of your treatment. If specific information is needed, we will need to **submit in writing** to your insurance company for benefits. This process takes approximately **6-8weeks**. Maximum allowances, deductibles and eligibility can vary from patient to patient. **If our office has obtained an authorization this not always a guarantee of payment.**

Although we are happy to assist you with your insurance billing needs, due to the number of different plan and policies available we are unable to have knowledge of each and every plan. If you have any questions regarding your specific benefits, please call your insurance company. Our primary goal is to improve and maintain your dental health needs.

__________**PLEASE INITIAL**

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Our On Time Appointment Policy

Your time is important to you, and we understand that. That's why we are making an on time commitment to you. We will make every effort to see you at your appointment time, and have your appointment finished at the appointed time. In order to make this possible, patient must arrive on time. If you are late for your appointment, we may have to reschedule you. That rescheduled appointment would be subject to our $25.00 missed appointment fee.

______________________________ ____________________

Signature of patient/responsible party Date

FRESNO PRO DENTAL
PATIENT ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signature: ______________________________

Patient Name: ______________________________

Patient Representative (if minor): ______________________________

Date: ______________________________

Witness: ______________________________

Additionally, by signing this form a 2nd time, I give my authorization to disclose health information

to: ______________________________

to assist with treatment and/or payment for services and allow the above named person to pick up records or x-rays for the named patient.

Signature: ______________________________

Patient Name: ______________________________

Patient Representative (if minor): ______________________________

Date: ______________________________

Witness: ______________________________

For Office 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 acknowledgements*
- *An emergency situation prevented us from obtaining acknowledgements*
- *Other (Please Specify) :* ______________________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________ E-Mail: ______________

Social Security #: ______________________________

SECTION B: TO THE PATIENT –PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other information matters about your protected health Information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our Notice, at any time by contacting:

Contact Person: **Charline or Corrina**
Telephone (559) 227-4120 Fax: (559) 228-6831
E-Mail: fresnoprodental@yahoo.com
Address: 237 W Shields Ave, Fresno CA 93705

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand the revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________ 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 payment activities and health care operations.

Signature: ______________________ Date: ______________

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

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include complete Consent in the patient's chart.