PATIENT INFORMATION

Welcome to Dr. Kim Trieu's office! We look forward to providing you excellent dental care.

Today's date _____

Last Name _____ First Name _____ Middle Initial _____

Date of birth _____ Age _____ Sex _____

Home address _____

City _____ State _____ Zip _____

Mailing Address if different _____

Home Phone _____ Cell phone _____ Can we text you? _____

Email Address _____ Can we email you? _____

Billing address (if different from above) _____

Employer/occupation _____ Business phone _____

Spouse's name _____ Spouse's phone _____

Emergency contact name and phone number _____

Primary dental insurance _____ ID No. _____

Group No. _____ Subscriber's name _____

Relation to Patient _____ Subscriber's Social Security No. _____

Subscriber's Date of birth _____ Subscriber's employer _____

Secondary dental insurance _____ ID No. _____

Group No. _____ Subscriber's name _____

Relation to Patient _____ Subscriber's Social Security No. _____

Subscriber's Date of birth _____ Subscriber's employer _____

Who may we thank for referring you? _____

Other family members/friends seen by us _____

MEDICAL / DENTAL HISTORY

1. Primary physician's name _____ Date of last visit _____

   Address/phone _____

2. Are you under a physician's care? ☐ YES ☐ NO

   Since when _____ Why _____

3. Are you taking any medications or substances (including vitamins/herbs) ☐ YES ☐ NO
   (If yes, please list medications in section to the right)

4. Are you allergic to any medications or substances? ☐ YES ☐ NO

5. Do you have any other allergies? ☐ YES ☐ NO

6. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?
   ☐ YES ☐ NO

7. Are you sensitive to any metals or latex? ☐ YES ☐ NO

8. Are you pregnant or suspect you may be? ☐ YES ☐ NO

9. Do you have or have you had any of the following medical conditions? (Check all that apply):

__ Heart attack/chest pain
__ Artificial joint replacement surgery
__ Artificial heart valve
__ Heart valve disease
__ Pacemaker
__ High blood pressure
__ Abnormal bleeding
__ Blood disorder (anemia/hemophilia)
__ Stroke
__ Cancer/chemotherapy
__ Diabetes
__ Tuberculosis
__ HIV+/AIDS
__ Hepatitis B/Hepatitis C
__ Kidney/liver/stomach problems
__ Epilepsy/Seizure disorder
__ Asthma/difficulty breathing
__ Thyroid problem
__ Drug/alcohol abuse
__ Psychiatric treatment (including depression & panic attacks)

10. Do you smoke? ☐ YES ☐ NO

    If yes, how long and how much? _____

    If no longer, when did you quit? _____

11. Do you have or have you had any of the following dental conditions? (Check all that apply):

__ Growths, sores or swollen areas in your mouth
__ Bleeding gums
__ Periodontal (gum) treatment
__ Bad breath
__ Orthodontic Treatment
__ Jaws click, crack, lock or pop
__ Clench or grind your teeth
__ Any teeth sensitive to heat, cold or sweets
__ Pain in or near ear

12. Do you have a night guard? ☐ YES ☐ NO

13. Are you having any dental discomfort at this time? ☐ YES ☐ NO

    If yes, please explain: _____

14. Name of previous dentist _____ Date of last visit _____

15. What type of toothbrush do you use? _____ Battery-powered or manual?

16. How frequently do you floss? Everyday 4-6x/wk 1-3x/wk Not often

17. How frequently do you brush? Everyday Mostly AM/PM Not often

18. Do you use a waterpik? ☐ YES ☐ NO

19. Is there anything else we should know about your health that was not covered in this form?

    _____

MEDICATIONS
If more room is needed please attach a copy of your medications.

ADDITIONAL WRITTING ROOM
If you answered YES to any of the questions please elaborate as needed in the space provided below:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____ Date _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I acknowledge and agree that I am responsible for and will pay for all regular charges, which is in effect on the dates of services rendered for items or services and treatment provided to me including any amount not paid by my insurance plan. **Payment for services is due at the time of services unless prior arrangements have been made**. If you are unable to keep your appointment, we respectfully request a 48 hours advance notice of cancellation. Failed appointments will be charged **$75.00 per hour** of scheduled operatory time. Late charge of **$5.00** applies along with **3% finance charge** monthly until balance is paid.

By signing below, I agree to the foregoing policies set forth herein by Kim Trieu, PLLC; I agree that regardless of the type of insurance coverage I may have, I understand and agree that I am ultimately responsible for payment of all dental fees for myself and/or my dependents.

Patient Name _____ Date _____

Signature _____ Date _____