NORTH EVERETT FAMILY DENTAL

Angela Shen Chianglin, DDS, PLLC

Patient Information

Welcome to Dr. Angela Shen's office. We look forward to providing you excellent dental care. If there have been any changes in your health history, please let us know.

Today's date _____

Last Name_____First Name_____Middle Initial_____

Date of birth_____Age_____Social Security Number_____

Home address_____

City_____State_____Zip_____

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_____

Who may we thank for referring you? _____

Other Family members/friends seen by us_____

Name of your medical doctor_____Date of last visit_____

Name of previous dentist_____ Date of last visit_____

Primary dental insurance_____Group No_____

Subscriber's name_____Relation to Patient_____

Subscriber's Social Security No_____ Subscriber's Date of birth_____

Subscriber's employer_____

Secondary dental insurance_____Group No_____

Subscriber's name_____Relation to Patient_____

Subscriber's Social Security No_____ Subscriber's Date of birth_____

Subscriber's employer_____

NAME:_____ Date:_____

Medical Health History

Are you currently seeing a physician for any medical treatment? _____

What are you being treated for?_____

Please list current medications_____

_____

Did your physician inform you to take antibiotics prior to surgery or dental treatment? Yes No

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

- o Heart attack/Chest Pain
- o Artificial heart valve
- o Heart valve disease
- o Pacemaker
- o High Blood pressure
- o Abnormal bleeding
- o Anemia/hemophilia
- o Stroke
- o Cancer/chemotherapy
- o Diabetes
- o Tuberculosis
- o HIV+/AIDS
- o Hepatitis B/ Hepatitis C
- o Kidney problem
- o Liver problem
- o Epilepsy/Seizure disorder
- o Asthma/Difficulty breathing
- o Thyroid problem
- o Artificial Joint Replacement surgery
- o Drug/Alcohol abuse

Please list any serious medical conditions that you have ever had:_____

_____

Are you allergic to any of the followings? (Check all that apply)

- o Penicillin
- o Erythromycin
- o Clindamycin
- o Aspirin
- o Acetaminophen
- o Ibuprofen
- o Codeine
- o Vicodin
- o Latex
- o Local Anesthetics
- o Others_____

_____

Do you smoke now?_____How long and how much?_____Did you smoke in past? _____

If so, when did you quit?_____Do you use smokeless tobacco? _____How often? _____

Are you pregnant ?_____ Are you nursing?_____

Dental Health History

What is the purpose of today's visit?_____

Are you currently in pain? Yes / No If yes, please explain:_____

Have you ever had a serious/difficult problem associated with previous dental work? Yes No

Do you or have you had pain/discomfort associated with your jaw joint (TMJ)? Yes No

Do you grind or clench your teeth frequently? Yes No Are your teeth sensitive? Yes No

Do you like your teeth/smile? Yes No If not, explain_____

Patient 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 (HIPAA). 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_____ Relationship to Patient_____

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 **$50.00** per *hour* of scheduled operatory time.

I agree to the foregoing policies set forth herein by Angela Shen Chianglin 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_____ Relationship to Patient_____

North Everett Family Dental
Angela Shen Chianglin, DDS, PLLC
2032 Colby Ave
Everett, WA 98201