ORCHID SPRINGS
DENTAL

Patient Name: _____ Age:_____
(Last) (First) (MI)

Male Female Single Married Minor Other_____

Birth Date: _____ Social Security #: _____

If patient is a minor, parent or guardian's name: _____ Relationship: _____

Preferred name: _____ Email address: _____

Home Address:_____ Cell Phone:( )_____
City: _____ State: ____ Zip code: _____ Home Phone:( )_____
Work Phone:( )_____

Emergency Contact
Name: _____ Relationship to Patient:_____
Home Phone: ( )_____ Work/Cell Phone: ( )_____

Whom can we thank for referring you to our practice?_____

Responsible Party (person responsible for payment on account)**:** ☐ **Self** **If not Self, please complete below**

Name: _____
Male Female Spouse Mother Father Other _____
Social Security #: _____ Birth Date: _____
Home Phone: ( )_____ Work Phone: ( ) _____
Address same as above
Home Address: _____
City: _____ State:____ Zip code:_____

Insurance Information

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
Name of Insured	**Relationship to Pt**	**Name of Insured**	**Relationship to Pt**
Insured Birth Date	**ID# or SSN**	**Insured Birth Date**	**ID# or SSN**

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependents) have dental insurance coverage with

_____
Name of Dental Insurance Company

and assigned directly to *Namthuyen T. Vu, DMD - Orchid Springs 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Responsible Party Signature_____ *Date*_____

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MEDICAL HISTORY

◯Yes ◯No Is your health generally good? If NO, explain_____
_____

◯Yes ◯No Has there been a change in your health within the last year? If YES, explain _____
_____

◯Yes ◯No Have you gone to the hospital or emergency room or had a serious illness in the last 3 yrs?_____

◯Yes ◯No Have you undergone any major surgeries within the past 3-5 yrs? If YES, please explain/when?_____

If necessary, in the event of needing a **MEDICAL CLEARANCE** for dental treatment, whom may we contact?
Physician Name: _____ Physician's Contact Number_____

Have you ever had any of the following? Please check those that apply

- ☐ Alcohol/Drug Abuse
- ☐ Asthma
- ☐ Chemotherapy/Radiation
- ☐ Endocarditis/Heart Infection
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Respiratory Disease
- ☐ Hi/Low Blood Pressure
- ☐ Osteoporosis/Osteopenia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Excessive Bleeding
- ☐ HIV+/AIDS
- ☐ Sinus Problems
- ☐ NONE OF THE ABOVE

- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Heart Disease
- ☐ Blood Disease
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Mental Disorder
- ☐ Prosthetic/Replace Heart Valve
- ☐ Sickle Cell Disease
- ☐ Ulcers/Colitis
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Herpes
- ☐ Shingles
- ☐ Tuberculosis
- ☐ NONE OF THE ABOVE

If there is anything checked above or any conditions not listed that needs further clarification, please explain below.

WOMEN ONLY: Please check all that apply

- ☐ Pregnant (1st Trimester)
- ☐ Pregnant (2nd Trimester)
- ☐ Pregnant (3rd Trimester)
- ☐ Taking Birth Control
- ☐ Nursing
- ☐ Breast Augmentation

Please check any of the following conditions that pertain to your health

- ☐ Latex Allergy
- ☐ Vicodin/Codeine Allergy
- ☐ Penicillin/Amoxicillin Allergy
- ☐ Sensitive to Epinephrine
- ☐ Other Medical Allergies
- ☐ Taking Blood Thinning Medication
- ☐ Taking Fosamax
- ☐ Severe Gag Reflex
- ☐ Anxiety at Dental Appointments
- ☐ Needs Antibiotic Pre-Medication - if checked, why is premed needed _____

If there is anything checked that needs further clarification, please explain below.

Medications- Please list any medications you are currently taking.

Name	Purpose

DENTAL HISTORY

Name and Location of Previous Dentist? _____ Date last exam?_____

1. Do your gums bleed when brushing / flossing? ◯ **Y / N** ◯
2. Are your teeth sensitive to hot/cold? ◯ **Y / N** ◯
3. Are your teeth sensitive to sweet/sour foods? ◯ **Y / N** ◯
4. Are you having pain with any teeth? ◯ **Y / N** ◯
5. Do you have any sores/lumps in your mouth? ◯ **Y / N** ◯
6. Have you had any head/neck/jaw injuries? ◯ **Y / N** ◯

7. Have you ever experienced any of the following;
- Clicking ◯ **Y / N** ◯
- Pain(joint, ear, side of face) ◯ **Y / N** ◯
- Difficulty opening/closing ◯ **Y / N** ◯
- Difficulty in chewing ◯ **Y / N** ◯

8. Do you have frequent headaches? ◯ **Y / N** ◯
9. Do you clench / grind your teeth? ◯ **Y / N** ◯
10. Do you bite your lips/cheeks? ◯ **Y / N** ◯
11. Have you ever had a difficult extraction in the past? ◯ **Y / N** ◯
12. Have you ever had any prolonged bleeding following extractions? ◯ **Y / N** ◯
13. Have you ever had Braces? ◯ **Y / N** ◯
14. Do you wear dentures/partials? ◯ **Y / N** ◯
15. Have you ever received Oral Hygiene Instructions? ◯ **Y / N** ◯
16. Do you like your smile ◯ **Y / N** ◯

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any member of her staff, responsible for any errors or omissions that I may have made in completion of this form.

Patient/Guardian Signature _____ Date _____

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DENTAL

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Agreement for Services and Payments

I understand that I am financially responsible for all charges incurred by me or my dependents and agree to pay for all charges not covered by my insurance company. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. By consenting to treatment, I acknowledge financial responsibility for completed work.

In consideration for the professional services rendered to me by this practice, I agree to pay for charges (copays) for services at the time of service, or within (15) days of the billing cycle if credit is extended. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my dental treatment.

The highest level of care and quality is placed in providing our patients with the best that dentistry has to offer. Unfortunately, we are unable to predict the longevity of any dental restorations. This is particularly true if there is a history of clenching, grinding, TMJ, broken crowns, and fillings.

To the best of my knowledge, I hereby certify that the above personal and insurance information is correct. I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of patient, parent or guardian Date

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Cancellation and Missed Appointment Policy

We require **TWO BUSINESS DAYS** notice to change or cancel your appointment. You may be charged up to $100 for any appointments that are missed or canceled with less than two business days notice. We understand that things do come up at the last minute from time to time and we will always take that into consideration. We are respectful of your time and appreciate that you respect the time you reserve for your appointments with us.

I have read the above conditions and acknowledge their content.

_____ _____

Signature of patient, parent or guardian Date

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I acknowledge that I have been given online access to the Dental Board of California's Dental Materials Fact Sheet.

_____ _____

Signature of patient, parent or guardian Date

I acknowledge that I have been given online access to this office's Notice of Privacy Practices.

_____ _____

Signature of patient, parent or guardian Date

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Treatment Consent:

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all mutually agreed upon treatment and employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand the using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

_____ _____

Signature of patient, parent or guardian Date

_____ _____

Doctor Signature Date