CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask our front desk staff. PLEASE PRINT.

Today's Date: _____

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D Referred by: _____

E-mail address: _____

Your Employer: _____ Occupation: _____

Work Number: _____ Cell Phone; _____ Other: _____

Your SS#:_____

Do You Have Dental Insurance? Y N Policy Holders name: _____

Policy Holders Date of Birth: _____ Policy Holders SS#_____

Insurance Company: _____ Plan/Group #:_____

Spouse or Parents Name: _____ Spouse Employer: _____

Spouse SS#:_____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that dental insurance policies are an arrangement between an insurance carried and myself and that I am personally responsible for payment of any and all services covered or non- covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature: _____ Date: _____

Guardian's Signature (For Minors):_____ Date: _____

Date of Last Dental Visit: _____

Any Concerns About Your Teeth You Would Like For Dr. Vang To Address Today? _____

_____

Are You Currently Taking Any Medications (If Yes, Please List All) _____

_____

Patient Name:_____ Date:_____

Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive.

Please answer the following questions:

Are you under a physician's care now? YES/NO

Physicians name _____ Phone Number_____

Have you ever been hospitalized or had a major operation? YES/NO If yes _____

Have you ever had a serious head or neck injury? YES/NO

Do you take, or have you ever 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 Nursing Taking Oral Contraceptives

Are you allergic to any of the following?

Asprin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Do you have, or have had, any of the following? Please Circle.

AIDS/HIV Positive	Cortisone Medicine	Hepatitis A B C	Recent Weight Loss
Anemia	Diabetes	Herpes	Renal Dialysis
Angina/Chest Pain	Drug Addiction	High Blood Pressure	Rheumatic Fever
Arthritis/Gout	Emphysema	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Fainting/Dizziness	Hypoglycemia	Sickle Cell Disease
Asthma	Frequent Cough	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Headaches	Kidney Problems	Stomach/Intestional
Blood Transfusion	Glaucoma	Leukemia	Stroke
Breathing Problems	Hay Fever	Liver Disease	Swelling of Limbs
Cancer	Heart Attack	Lung Disease	Thyroid Disease
Chemotherapy	Heart Murmur	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Pacemaker	Pain in Jaw Joints	Tumors
Congenital Heart Disorder	Heart Disease	Psychiatric Care	Ulcers
Convulsions/Seizures	Hemophilia	Radiation Treatment	Venereal Disease

OTHER: _____

Patient Consent For Use & Disclosure Of Protected Health Information

With my consent, Brookdale Dental Care, Kong Vang DMD, PA may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Brookdale Dental Care's Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brookdale Dental Care reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brookdale Dental Care as well.

With my consent, Brookdale Dental Care may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my dental care.

With my consent, Brookdale Dental Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

By signing this form, I am consenting to Brookdale Dental Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Brookdale Dental Care may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

Authorization to Pay Doctor

I hereby authorize and direct payment of any dental expense benefits allowable to Dr. Vang as payment toward the total charges for professional services rendered. These payments will not exceed my indebtedness to Dr. Vang. I agree that a photo copy of this agreement shall serve as the original.

_____ _____

Signature Date

Authorization to Pay/Release is granted to: Brookdale Dental Care, Kong Vang DMD PA

FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. We will give you an estimate (if requested) of the fees for service before they are performed or rendered.
3. After coverage and deductible are verified, this office will accept assignment on polices provided the Insured/patient signs an appropriate assignment of benefit. (Authorizing payment to be sent to the Doctor) a signed copy of this form will serve as authorization.
4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment at each dental appointment. Payment arrangements must be approved prior to dental visit, by the office manager.
6. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
7. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
8. All insurance payments are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.
9. If you receive any checks from your insurance company, you agree to bring these into our office so that we may determine if the check is an assignment to this office.
10. If the patient discontinues care for any reason, the bill is due and payable in full immediately, regardless of any claims submitted.
11. If you change insurance companies or employers, you agree to provide this office with current information immediately.
12. This office accepts: Visa, MasterCard, Discover, American Express, Care Credit, personal checks, and cash.
13. If you have questions concerning these or any other matter, please speak with the Receptionist or Office Manager prior to seeing Dr. Vang.
14. Our office requires a 24 hour notice if you need to cancel or reschedule your appointment. Failure to do so may result in a $50.00 cancellation fee.
15. If a patient is a minor, under the age of 18 they must be accompanied by a parent or legal guardian. If a parent isn't present a consent form allowing our office to treat individuals under age 18 must be signed prior to their appointment.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Brookdale Dental Care. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____ _____

Please ***print*** your name Please ***sign*** your name Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents, and any care takers who can have access to this patient's records)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT, & BILLING INFORMATION** VIA:

- Cell phone/text confirmation
- Home phone confirmation
- Work confirmation
- Email confirmation

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** TO BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Text message
- Email message

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on the Acknowledgement but did not because:

It was emergency treatment_____ I could not communicate with the patient_____

The patient refused to sign _____ The patient was unable to sign_____

Other: _____