Email:

GENERAL INFORMATION (please print)

Cell Phone:

Patient Name_______________________________________ Home Phone______________

Home Address____
Street city state zip

Birthday____________ Age_____ Sex M__ F__ Social Security #________________ Driver Lic. #____________

Occupation________________ Employer__________________________ Business Phone______________

Business Adress____
Street city state zip

Spouse's Name_______________________________________ Employer______________

Business Address_____________________________________ Business Phone______________

Whom may we thank for referring you to our office? ______________________________________

If patient is a minor (less than 18 years of age) give names of either parents or legal guardians:

Name________________ relationship__________________ address____________________

Name________________ relationship__________________ address____________________

Nearest relative not living with you_______________________________ Phone______________

Name of you Physician (M.D.) _____________________________ City________________ last seen__________

Name of your former Dentist_______________________________ City________________ last seen__________

INSURANCE INFORMATION (please fill in if you have coverage)

Dental Insurance Co.______________________________________ Local Union No.______________

Group No.____

Spouse's Dental Insurance Co._______________________________ Group No.______________

Spouse's Social Security #_________________________________ Local Union No.______________

FINANCIAL INFORMATION

1. Payment must be made for professional services as they are rendered. A finance charge of 1 ½ % (APR of 18%) will be added for unpaid balance over 30 days.
2. Finance arrangement preferred CASH____ CHECK_____ CREDIT CARD_____
3. Patient with DENTAL INSURANCE:

If you direct the insurance company to pay their share of the cost directly to this office (this is called Assigning the Benefits) we will give you credit for this anticipated amount. Your insurance company will not be billed for services rendered until treatment has been completed. Often these payments are not received until two or three months, after being submitted for payment. Therefore, we do ask that you pay your estimated share of your treatment as it is rendered. However, you are still responsible for the total charges until we receive payment from your carrier. Please realize that professional services are rendered to a person, and not to the insurance company.

Assignment of Benefits: I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

____
Signature of Insured Date

CONSENT:

Permission is granted to the dentist and staff of his employ to perform procedures, including the giving of anesthetics or photographs which may be necessary for my treatment or for purposes of dental and medical consultation and dental education. The undersigned hereby have read and understand the above financial information and take the financial responsibility of the patient above. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I understand that X-ray films and other diagnostic aids remain the property of the dentist and may not be released to the patient or to other dentists.

____________________ ____
Date Signature of Patient, Parent or Guardian

HEALTH INFORMATION

All information is confidential.

☐ Yes ☐ No 1. Have you come to this office for the relief of pain?
If yes, where is the pain? ___________

☐ Yes ☐ No 2. Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

☐ Yes ☐ No 3. Has a dentist or hygienist shown you how to clean you teeth?

☐ Yes ☐ No 4. Do you have sores, swellings or blisters on your gums, cheeks or lips?

☐ Yes ☐ No If "yes", have they been present longer than 3 – 4 weeks?

☐ Yes ☐ No 5. Have you had orthodontic treatment to straighten your teeth?

☐ Yes ☐ No 6. Do you have any dental implants?

☐ Yes ☐ No 7. Do you have clicking/popping jaw?

☐ Yes ☐ No 8. Do you have bleeding or infected gums?

☐ Yes ☐ No 9. Have you ever had an unusual reaction to dental anesthesia (gas or 'shots')?

☐ Yes ☐ No 10. Are you now being treated or have you been treated within the last year by a physician?

☐ Yes ☐ No 11. Following injuries or dental treatment, have you had bleeding problems?

☐ Yes ☐ No 12. Is there a history of diabetes in your family?

☐ Yes ☐ No 13. Are you thirsty most of the time?

☐ Yes ☐ No 14. Have you recently lost weight unintentionally (with good appetite)?

☐ Yes ☐ No 15. Have you ever used intravenous drugs?

☐ Yes ☐ No 16. Have you had eye trouble recently?

☐ Yes ☐ No 17. Do injuries or cuts take longer to heal now than they did previously?

☐ Yes ☐ No 18. Does your mouth feel dry or do you have a burning sensation of lips or tongue?

☐ Yes ☐ No 19. Have you taken or been given injections of steroids such as cortisone?

☐ Yes ☐ No 20. Do you smoke or use tobacco regularly?

21. How would you describe your general health?
☐ poor ☐ fair ☐ good

☐ Yes ☐ No 22. Have you ever taken phen-fen?

Date of last medical examination?
____

Have you become sick from, shown an allergy to, or been told *not* to take:

☐ Yes ☐ No Latex
☐ Yes ☐ No Antibiotics (penicillin, etc.)
☐ Yes ☐ No Codeine
☐ Yes ☐ No Novocaine or other dental anesthetics
☐ Yes ☐ No Other drugs or medicines
____

Are you now:

☐ Yes ☐ No Pregnant
☐ Yes ☐ No On a prescribed diet
☐ Yes ☐ No Using thyroid
☐ Yes ☐ No Using hormones (including birth control pills)
☐ Yes ☐ No Using anticoagulants
☐ Yes ☐ No Using Dilantin

Are you now taking or using medicines for:

☐ Yes ☐ No Diabetes (pills or 'shots')
☐ Yes ☐ No Nerves (tranquilizers)
☐ Yes ☐ No Sleeping
☐ Yes ☐ No Heart or blood pressure (digitals, nitroglycerine, resperine)
☐ Yes ☐ No Blood (liver or iron pills, etc.)
☐ Yes ☐ No Stomach trouble (ulcer or other)
☐ Yes ☐ No Headaches
☐ Yes ☐ No Arthritis or rheumatism
☐ Yes ☐ No Allergy

List all prescription and non-prescription drugs you are taking:

1. ___________
2. ___________
3. ___________
4. ___________
5. ___________
6. ___________
7. ___________
8. ___________
9. ___________

Have you ever had any of the following?

☐ Yes ☐ No Heart disease
☐ Yes ☐ No Shortness of breath without exercise or when lying down
☐ Yes ☐ No Swelling of ankles or feet
☐ Yes ☐ No Pain, pressure, or tight feeling in chest
☐ Yes ☐ No Heart attack, stroke
☐ Yes ☐ No Rheumatic fever, heart murmur, heart valve prolapse
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Fainting spells, convulsions, epilepsy
☐ Yes ☐ No Frequent headaches (2 or 3 a week)
☐ Yes ☐ No A blood transfusion
☐ Yes ☐ No Nervous breakdown, psychotherapy
☐ Yes ☐ No Lung trouble (TB, asthma, emphysema)
☐ Yes ☐ No Hepatitis, liver disease, jaundice, HIV+
☐ Yes ☐ No Arthritis, sore joints, bone or joint implants
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Excessive bleeding
☐ Yes ☐ No Blood trouble, anemia, leukemia, tumor, cancer
☐ Yes ☐ No VD (syphilis, gonorrhea)
☐ Yes ☐ No Radiation, radium or cobalt treatments
☐ Yes ☐ No AIDS, HIV+
☐ Yes ☐ No Kidney disease

Patient Signature ___________ Date ___________ Dr. Init. ___________
(parent or guardian) Date ___________

Dr. Tom Chen, D.D.S. • 19010 Brookhurst St. • Huntington Beach, CA 92646 • (714) 968-8989

GENERAL INFORMED CONSENT

1. WORK TO BE DONE
I understand that I am having the following work done. Fillings { }, Crowns { } , Impacted teeth removed { }, Root Canal { }, X-rays { }, Dentures { }, others ____________________________.

2. DRUGS AND MEDICATION
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permissions to the dentist to make any/all changes and additions as necessary.

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal, crowns and periodontal surgery, etc.), and I authorize the dentist to remove the following teeth . and any others necessary for reasons in #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissues that can last and indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

5. CROWNS BRIDGES AND CAPS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they stay on until the permanent crowns are delivered. I realize the final opportunity to make any changes to my new crown, bridge; cap (shape, fit, size and color) must be before cementation. It is my responsibility to return for permanent cementation within 20 days of tooth preparation. Excessive delay may allow tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

6. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

7. PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse affect on my periodontal conditions.

8. FILLINGS
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that significant sensitivity is a common after effect of a newly placed filling.

9. DENTURES
I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate denture placement (after extraction) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later, which will not be included in the denture fee. I understand it is my responsibility to return for the delivery of the denture. Failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is necessary due to my delay of more than 30 day, there will be an additional charge.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.

I hereby authorize any of the doctors of dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay attorney's fees, collection fees or court costs that may be incurred to satisfy this obligation.

I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACT SHEET AS REQUIRED BY LAW.

Signature of Patient ____________________ Name ____________________ Date __________

Signature of Doctor ____________________ Date ____________________

Tom T.P. Chen, D.D.S. 19010 Brookhurst St., Huntington Beach, CA 92646 (714) 968-8989

PATIENT CONSENT FORM

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notices of Privacy Practices* prior to singing this consent. I understand that his organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practice.*

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

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name ______________________________

Signature ______________________________

Relationship to Patient ______________________________

Date: ______________________________

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A Tooth Doctor for Kids
Pediatric Dentistry

19010 Brookhurst St.
Huntington Beach, CA 92646
(714) 968-8989P (714) 845-9055F
www.atoothdoctorforkids.com

FINANCIAL POLICY

OVERVIEW OF FINANCIAL RESPONSIBILITY:

Practice Responsibilities: *To submit claims to insurance and statements to the patient/responsible party based on the information provided to us by you. To provide patients with the network and billing information that is available to us.*

Patient/Parent/Guardian Responsibilities: *To understand their own insurance network and benefits. To assure that our office is provided with the most current information known about their insurance and to inform us of any changes in insurance or demographics (address, phone numbers, etc.). To pay within 30 days any balance shown as patient responsibility (e.g. co-payments, share of cost, deductibles and co-insurance).*

PATIENT NAME: ________________________________ DOB: ______________

PARENT/GUARDIAN/
RESPONSIBLE PARTY: ____

DETAILED POLICIES:

(Please Initial)

____ ***Patients must understand their OWN network, plan benefits and plan limitations:***

Your insurance is an agreement between you and your insurance company. All charges are ultimately your responsibility whether you have insurance or not. Not all services are covered under all plans, regardless whether our dentist consider it dentally necessary. Because there are so many insurance plans, it is not possible for us to know the specific details of your coverage. We recommend for you to check with your insurance company to get the details of your benefits, your eligibility and if your plans network includes our office. This way you will be well informed of your benefits and share of costs at our offices. You need to authorize your insurance to pay us directly. We will do our best to check your eligibility and general benefits, but there are no guarantees by your insurance company of those benefits. We do our best in checking your eligibility but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered.

If your insurance changes, you must notify us immediately even if you do not yet have your insurance card. It is your responsibility to make our offices aware of your insurance changes a few days prior to your appointment. Insurance coverage may change at the beginning of the year. Every patient elected his or her own insurance coverage and dental plan. A dental plan and its benefits can change year to year based on your employer and/or what a patient may elect. Employers may elect to negotiate benefits at any time thus resulting in changes in your coverage. Only you, the insured, will be notified of those changes.

Insurance benefits vary among dental plans. If requested and as a favor to our patients, we will contact your insurance provider regarding specific procedures. There is no guarantee of coverage over the phone until after submitting completed procedures for payment and an Explanation of Benefits is received. It is up to your insurance company to decide on coverage. We strongly recommend you contact your insurance company to find out about your coverage so there are no surprises. Your insurance coverage and any payment is between you and your insurance company.

____ ***Deductibles, Coinsurance and/or share of costs:***
Any deductible, coinsurance, and/or your share of cost is collected at the time services are rendered. We make an estimation of your share of cost based on what we know about your insurance plan coverage. Our estimation may be more, less or exactly correct. Explanation of benefits sent to you and to us by your insurance company will determine the remaining balance if any.

____ ***Bills are due upon receipt:***
Bills are due upon receipt of mailed statements or you can contact our office and pay by phone with a credit card. Your account balance begins on the day services are rendered (insurance or non-insurance holders). Following 30 days from day of service 18% interest or as allowed by law will be processed for being delinquent. A $50 late payment fee for each month will be added. We recommend contacting the office upon receipt of mailed statements. There is a $25 fee for returned checks.

____ ***Cancellation/No Show Fees***
Appointments are reserved for your child. Out of courtesy for other patients who need appointments, please notify us 48 business hours prior to your appointment. A $50 per patient charge will be made for all failed or cancelled appointments without a minimum of 48 business hours' notice. Exception: All sedation deposits are non-refundable.

____ ***Video/Photo Policy:***
To respect the privacy of our patients, families, doctors and staff, photos and videos are not permitted.

Agreement by patient/parent/guardian: *I have read and understand the financial policies set forth above and agree to them as outlined.*

PATIENT NAME: ____

PATIENT/GUARDIAN SIGNATURE______________________________________
Date

RELATIONSHIP TO PATIENT ____________________________________
(if applicable)

**** Thank you for taking the time to understand our financial policies ****