

# ROSEVILLE DENTAL CENTER

Henry Vong, DDS • 1771 Pleasant Grove Blvd., Ste. 180 • Roseville, CA 95747 • 916-772-3847 • www.RosevilleDentalCenter.com

## WELCOME

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

### ABOUT YOU

Today's Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_

I prefer to be addressed as: \_\_\_\_\_ Circle One: **Male Female**

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Circle One: **Single Married Widowed Divorced Separated Partnered**

Spouse's Name: \_\_\_\_\_

Spouse's Birthdate: SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

When and where are the best times to reach you? \_\_\_\_\_

Other Family Members Seen by Us: \_\_\_\_\_

### EMERGENCY CONTACT (Specify someone who does not live in your household)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### DENTAL HISTORY

Why have you come to our office today? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

What was done? \_\_\_\_\_

Have you ever been told that you require antibiotics before dental treatment? **Yes No**

Have you ever had a serious/difficult problem associated with any previous dental work? **Yes No** Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes No**

How would you classify your current dental health? **Excellent Good Fair Poor Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? **1 2 3 4 5 6 7 8 9 10**

Would you like whiter teeth? **Yes No** Would you like fresher breath? **Yes No** What else about your smile would you like to change? \_\_\_\_\_

Do you feel anxiety about dental treatment? **Yes No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? **1 2 3 4 5 6 7 8 9 10**

On average, how many times a day do you brush? \_\_\_\_\_ How many times a week do you floss? \_\_\_\_\_ What type of bristles does your toothbrush have? **Soft Medium Hard**

### DENTAL INSURANCE

Person Responsible for Account (If other than yourself): \_\_\_\_\_

Do you have dental insurance coverage? **Yes No**

Dental Insurance Co. Name: \_\_\_\_\_

Dental Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dental Insurance Co. Phone: \_\_\_\_\_

Group # (Plan, Local, or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured's Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I understand that I will be required to pay my estimated portion of Dr. Vong's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Are you in pain? **Yes No** If yes, for how long? \_\_\_\_\_

Phone: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Date of Last Cleaning: \_\_\_\_\_ Date of Last Dental X-rays: \_\_\_\_\_

## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- |   |  |                               |
|---|--|-------------------------------|
| Are you under a physician's care now?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medication containing oral or IV bisphosphonates? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you on a special diet?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                               |
| Do you use tobacco?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                               |
| Do you use controlled substances?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                               |

**Women:** Are you Pregnant/Trying to get pregnant?  Yes  No      Taking oral contraceptives?  Yes  No      Nursing?  Yes  No

**Are you allergic to any of the following?**

- Aspirin    Penicillin    Codeine    Local Anesthetics    Acrylic    Metal    Latex    Sulfa Drugs    Other

If yes, please explain: \_\_\_\_\_

**DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?**

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian \_\_\_\_\_

Date \_\_\_\_\_

### AUTHORIZATION AND RELEASE

Thank you for choosing Roseville Dental Center for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- **Allergic reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
- **Long-term numbness** (parasthesia). Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness.
- **Muscle or joint tenderness:** Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- **Sensitivity** in teeth or gums, infection, or bleeding.
- **Swallowing or inhaling** small objects.

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

\_\_\_\_\_  
Signature of patient or parent/guardian, if minor

\_\_\_\_\_  
Date

### AUTHORIZATION & RELEASE & PAYMENT OPTIONS

- I authorize Dr. Vong and Roseville Dental Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to Dr. Vong and Roseville Dental Center insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

### PAYMENT OPTIONS

For your convenience, we offer the following methods of payments. Please check the option you prefer:

Cash \_\_\_\_\_ Personal Check \_\_\_\_\_ Visa \_\_\_\_\_ Master Card \_\_\_\_\_ CareCredit \_\_\_\_\_ I wish to discuss the financial policies \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or parent/guardian, if minor

\_\_\_\_\_  
Date

### CONSENT TO RELEASE / REQUEST DENTAL RECORDS (if applicable)

I, \_\_\_\_\_ (patient name), do hereby consent and authorize \_\_\_\_\_ (doctor's name) to disclose to Roseville Dental Center information in my dental record, including current and previous dental records for other practitioners, hospitals, and/or clinics which are part of my record.

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Reason for Transfer: \_\_\_\_\_

Authorization: I certify that this request has been made voluntarily and the information given above is accurate to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send the following records to: Roseville Dental Center 1771 Pleasant Grove Blvd., Ste. 180 • Roseville, CA 95747

- Radiographs
- Periodontal Charting
- Progress Notes

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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 and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this 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 above 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 healthcare 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.

Patient name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_