Patient Information

(correct and complete as necessary)

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell phone): _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Date of last Dental Cleaning _____

Previous Dentist _____ Reason for leaving (if applicable) _____

Reason for this visit: _____

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

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Date_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
  Date_____
- ☐ Heart Murmur
  Date_____
- ☐ Hepatitis
  Type_____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
  Date_____
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation/Chemo.
  Date_____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
  Date_____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Fosamax / Actonel?

OTHER:

- ☐ _____
- ☐ _____

☐ Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

☐ Are you taking any prescription medication? _____

_____
(please attach list if necessary)

☐ Are you taking any over the counter medication? _____

☐ Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

☐ Are you now under the care of a physician? ☐ Yes ☐ No (do not include if regular check up only)
If yes, please explain: _____

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

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

☐ AZ republic ☐ Daily News Sun ☐ Grand Times ☐ School ☐ Work ☐ Other _____

Responsible Party Information

Please fill this out if you are the parental guardian, power of attorney, or responsible for treatment decision and financial arrangements

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

Office Policy

Cancellations/Appointment Changes:

At least 24 hours notice is required for cancellation and/or rescheduling appointments. Please call during office hours because the after-hours answering service does not accept appointment changes.

Failure to notify the office will result in a $45 fee per hour of scheduled time.

Financial:

Payment is expected on the day that dental services are rendered.

Financial arrangements must be made in advance as a condition of your treatment by this office.

If your account requires collection proceedings, you will be responsible for the collection fees, legal fees, in addition to the balance and interest. A service charge of 1-1/2% per month (18% per annum) will be charged on unpaid balances exceeding 60 days, unless previously written financial arrangement are satisfied.

Treatment Plan:

A signed treatment plan is required prior to any dental treatment. This signature acknowledges that you understand all aspects of the treatment discussed and you accept your estimated financial responsibility.

The fee estimate given for the dental care can only be extended for a period of 30 days from the date on the treatment plan.

Insurance:

Reimbursement from your insurance is not guaranteed, the patient is ultimately responsible for all charges.

The estimated co-insurance payment is subject to change. Coverage approximate is based on the information provided by your insurance during verification and may not disclose specific restrictions.

The patient is responsible for all denied claims or procedures. If the claim not paid by the insurance in a timely manner (45 days), the unpaid balance will be immediately due by the patient. The patient can then contact the insurance company for a reimbursement.

I have read and accept the terms of the above specified policies

Signature: _____ **Date** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

PRIVACY POLICIES ACKNOWLEDGEMENT

FAMILY & COSMETIC DENTISTRY
THOMAS T. PHAM, DDS

Patient name:_____ Date: _____

Patient date of birth: _____SS#: _____

I verify that the information given on the Health History is true and correct.

- ☐ I understand that the office and staff of Dr. Thomas Pham will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone numbers.
- ☐ I understand that there may be times when the Doctor and staff will need to speak with me regarding an appointment time, dental consultations or financial arrangements. If I am not at the numbers given, they have my permission to leave a brief message at my home or other numbers provided.
- ☐ I give permission to the Doctor and staff to correspond with my general physicians, hospital faculty or specialists that I am under care with.
- ☐ I understand that my dental health information will only be given to me or my legal guardian and can only be given to my spouse or other family members with my written consent.
- ☐ If I request, I will be given a full and complete copy of the HIPPA privacy policy.
- ☐ If there are specific restrictions on the use of my Personal Health Information, I will notify the staff at the office of Dr. Thomas Pham in writing of these restrictions.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian