PerfectSmile Dental Practice

8735 Center Prkway, Suite #150, CA 95823 (916)714-3410

Patient Information

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Social Security # _____

Address _____

City _____

State_____ ZIP _____

Sex ❑ M ❑ F Age _____

Date of Birth _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorce ❑ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Email Address_____

Preferred Spoken Language _____

Spouse's Name _____

Birthdate _____ SS# _____

Whom may we thank for referring you? _____

**** Appointment Cancellation Fee : ****

If for any reason you could not make it to your appointment, please give us a call to cancel 24 hours in advance, otherwise there will be a $50.00 cancellation fee charged to your account!!

Account Billing

Who is responsible for this account? _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent ❑ Guardian

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company (ies)

Dr. **My Hanh Trieu, D.D.S.** all insurance benefits, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____)_____ Work (_____)_____ Ext _____ Cell Phone (_____)_____

Best time and place to reach you _____ ❑ Morning ❑ Afternoon ❑ Evening ❑ Anytime

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____)_____ Work Phone (_____)_____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/ State _____

Date of last dental visit _____

Date of last x-rays _____

Place a mark on "yes" or "no" to indicate if you had any of the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blister on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Chew on one side of the mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar Smoking	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth.	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Are you now under the care of a physician? ❑ Yes ❑ No
If yes, please explain: _____

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

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

Do you have any health problems that need further clarification? ❑ Yes ❑ No
If yes, please explain: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" ❑ Yes ❑ No
These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever experienced any of the following? Please examine each one and circle YES or NO:

Yes / No AIDS/HIV	Yes / No Glaucoma	Yes / No Nervous Disorders	Yes / No Tumors
Yes / No Anemia	Yes / No Growths	Yes / No Pacemaker	Yes / No Ulcers
Yes / No Arthritis, Rheumatism	Yes / No Hay Fever	Yes / No Radiation Treatment	Yes / No Venereal Disease
Yes / No Artificial Joints	Yes / No Head Injuries	Yes / No Respiratory problems	Yes / No Codeine Allergy
Yes / No Asthma	Yes / No Heart Disease	Yes / No Rheumatic Fever	Yes / No Penicillin Allergy
Yes / No Blood Disease	Yes / No Heart Murmur	Yes / No Rheumatism	Yes / No Osteoporosis
Yes / No Cancer	Yes / No Hepatitis	Yes / No Sinus Problems	
Yes / No Diabetes	Yes / No High Blood Pressure	Yes / No Stomach Problems	Medication:
Yes / No Dizziness	Yes / No Jaundice	Yes / No Stroke	_____
Yes / No Epilepsy	Yes / No Kidney Disease	Yes / No Tuberculosis	
Yes / No Excessive Bleeding	Yes / No Liver Disease	Yes / No Pregnancy	Other :
Yes / No Fainting	Yes / No Mental Disorders	Due Date: _____	_____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____)_____

Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other _____

_____

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. _____ **(Please Initial)**

Consent For Services

As a condition of your treatment by the office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.
This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However this office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written arrangements are satisfied.
I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of patient examination.
In consideration for the professional service rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
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.
I have read the above conditions of treatment and payment and agree to their consent.

_____	_____	_____
Signature of Patient, Parent or Guardian	Date	Relationship to Patient
_____	_____	_____
Signature of Guarantor of Payment Responsible Party	Date	Relationship to Patient

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment; and is a very important part of your exchange with our Practice for services rendered. The following is a statement of our financial policy, which we would like you to read, and sign prior to any treatment.

FULL PAYMENT OF FEES & COPAYMENTS ARE REQUESTED AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, CARE CREDIT, AND OTHER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL.

Please indicate that you have read each policy by placing your initials at the end of each section below:

Dental Insurance

Please remember that your dental insurance is your responsibility and only a supplement to cover dental expenses but we can help. **Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee.** As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Our estimates are based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make a payment. After this time all inquiries (follow-up) and payments due become your responsibility. It is necessary that you accept responsibility for full payment of service fees not paid by insurance regardless of the reason for non-payment. X_____

Adult Patients

Notification of changes in insurance, medical history, martial status, residence and telephone numbers are your responsibility for yourself and minor children prior to your appointment. X_____

Minor Patients

It is state law for a parent/guardian of a minor child under the age of 16 to remain in the office while the child is being treated. The parent/guardian **accompanying** a minor is responsible for payment of all charges. For patients 16 years or older who come unaccompanied by a parent/guardian; treatment may be performed following pre-payment for services by the responsible parent or guardian. X_____

Missed Appointments

Since providing quality treatment for all our patients in a timely manner is a major focus in our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor. There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hour notice and you contact us during business hours. This would allow us to give this time to another patient who is in need and waiting for an appointment. Not showing for 2 appointments will result in a $50.00 reservation fee being required to reserve time in our schedule for future appointments. 3 or more missed appointments will result in the need for pre-payment for your visit. Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice. X_____

Dental Records & X-rays:

Pursuant to California Law, our office is required to keep dental records for 7 years. For a printed copy of full dental records, there will be a charge of $35.00. For a printed copy of the radiographs (x-rays) only, the charge will be $20.00. We will send a printed copy of dental records / X-rays once payment is received. We can do our best to scan and print out the copy of x-rays, but the quality of a copy would be subjective to the x-ray reader and may not be 100% duplicated as the original. X_____

Finance Charges and Outside Collections

A monthly finance charge of 1.5% will be charged to all accounts past 60 days. If any unpaid balance becomes 90 days past due, there will be a 30% collection fee added to your account balance. If in default, you are responsible to pay for services rendered, including reasonable attorney's fees and costs of collections. Non-sufficient fund checks will be accessed a $45.00 service charge. In addition, refund requests on pre-paid services or credit balances are subject to a 30-day processing period and a 5% administrative handling fee up to a maximum fee of $300.00. X_____

Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

_____ _____ _____

Signature of Patient or Responsible Party **Print Name** **Date**