

luxury

DENTAL STUDIO

PERSONAL INFORMATION

Today's date _____

First name _____ Middle Initial _____ Last Name _____

I prefer to be called _____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Cell Phone _____ Work Phone _____ Home Phone _____

Do we have permission to text you? Yes _____ No _____

Primary contact number (Check one) Cell _____ Work _____ Home _____

Email _____ Employer _____

Spouses's Name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Emergency contact person / contact number _____

DENTAL INFORMATION

Reason's for today's visit _____

Are you currently in pain? Yes _____ No _____ If so please describe _____

Do you have any dental problems right now? Yes _____ No _____ If so please describe _____

Have you ever had problems with previous dental treatment? Yes _____ No _____

If so please describe _____

Anything we can do to improve upon your last dental treatments? _____

Please rate your level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

MEDICAL HISTORY

PATIENT'S 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.

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

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

Do you have, or have you had, any of the following?

- | | |
|------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia Angina | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No |

- | | |
|---------------------------|--|
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blister | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No |
| Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No |

- | | |
|---------------------------|--|
| Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No |
| Easily Winded | <input type="radio"/> Yes <input type="radio"/> No |
| Emphysema | <input type="radio"/> Yes <input type="radio"/> No |
| Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No |
| Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No |
| Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No |
| Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No |
| Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No |

Do you have, or have you had, any of the following?

Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Hay Fever	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No
Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No
Herpes	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No

Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Leukemia	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No

Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Shingles	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? 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: _____

Comment: _____

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 _____

NAME OF PATIENT, PARENT, or GUARDIAN (Print) _____

WITNESS SIGNATURE _____ DATE _____

DR. SIGNATURE _____ DATE _____

DENTAL HISTORY

Approximate Date of last cleaning _____

Procedure(s) done at last dental visit _____

Are you looking for a change in the way your smile looks? Yes No

If you could change anything about your teeth, it would be (Check all that apply)

- Color of your teeth
- Size/Shape of your teeth
- Gaps between your teeth
- Too much or too little of teeth show when you smile
- Too much or too little gum shows when you smile
- Alignment of your teeth

Other (Please describe) _____

Do you have? (Check all that apply)

- Sensitive or receding gums
- missing teeth
- Teeth sensitive to heat / cold
- Concern about bad breath
- Worn / broken / chipped teeth
- Old crowns that have dark edges at the top
- Teeth sensitive while chewing
- Old or discolored fillings

Other (Please describe) _____

Have you ever experienced? (Check all that apply)

- | | | | |
|-------------------------------------|--|---------------------------------------|--|
| Periodontal disease / gum treatment | <input type="radio"/> Yes <input type="radio"/> No | Discomfort in your jaw join (TMJ/TMD) | <input type="radio"/> Yes <input type="radio"/> No |
| Orthodontics treatment | <input type="radio"/> Yes <input type="radio"/> No | Your bite adjusted or balanced | <input type="radio"/> Yes <input type="radio"/> No |
| Oral Surgery / wisdom teeth | <input type="radio"/> Yes <input type="radio"/> No | Serious injury to the mouth or head | <input type="radio"/> Yes <input type="radio"/> No |
| A bite plate or mouth guard | <input type="radio"/> Yes <input type="radio"/> No | Chronic bad breath | <input type="radio"/> Yes <input type="radio"/> No |
| Snoring | <input type="radio"/> Yes <input type="radio"/> No | Grinding of teeth (day or night) | <input type="radio"/> Yes <input type="radio"/> No |

If yes to any of the previous questions, please describe _____

Do you require antibiotics before dental treatment? Yes No

If Yes, why? _____

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Biophosphonates) Yes No

Is there anything else about your past dental treatment(s) that you would like to know?

DENTAL INSURANCE

Primary Carrier:

Insurance co. name _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Date of birth of Insured _____ Insured's employer name _____

Secondary Carrier:

Insurance co. name _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Date of birth of Insured _____ Insured's employer name _____

If the patient is a minor:

Name of parent or legal guardian and relationship _____
Is this parent or legal guardian currently a patient in our office? Yes _____ No _____

OFFICE AND FINANCIAL POLICY

- Our mission is to deliver the finest, most cost effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future's treatment.
- Payment is due at the time services are rendered. We accept: Cash, Visa, MasterCard and American Express.
- Insurance benefit are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment, insurance companies may not pay for all your cost. Your insurance policy is a contract between you and your insurer.
- As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all cost of collection, including attorney fees, court costs and collection agency fees (35% standard collection / 50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.
- We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. **A minimum charge of \$50 per hour may be posted to your account if an appointments cancelled without a 48 hour advanced notice.** As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.
- Any accounts overdue for patient payment in excess of 45 days are subjected to an interest fee of 18% per annum. A returned check fee of \$25 will be added to your account balance for any check returned to us as non sufficient funds (NSF).
- Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable directly to Thao Ngo, DDS.

I have read and understand this financial policy

PRINTED NAME

SIGNATURE

DATE

PHOTOGRAPHY RELEASE

I _____, hereby authorize LUXURY DENTAL STUDIO to take photographs and videos of my face, jaws, and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publications or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date

HIPPA PRIVACY

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

The Purpose of this form is used to obtain written acknowledgement of Receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this Notice of Privacy Practices.

Please Print Name

Signature of Patient or Guardian

Relationship To Patient

Date

For Office Use Only

We attempted to obtain written acknowledgement of recipe of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

- Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends:

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and • as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

THANK YOU!
FOR CHOOSING LUXURY DENTAL STUDIO
Dr. Ngo & Team