Date_____

Mangrove Bay Dentistry

Family & Cosmetic Dental Care

"Tranquility is Gentle Care"

NEW PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

Chief complaint/ Reason for visit: _____

ABOUT YOU

Patient name: _____ I prefer to be called: _____

[ ] Male [ ] Female [ ] Single [ ] Married [ ] Child [ ] Other Birth Date: _____ Age: _____

Cell: (_____) _____ E-mail: _____

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ S.S. #: _____

Employer: _____ How long there? _____
Work: (_____) _____ ext. _____ Occupation: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date: _____
Relation: _____ S.S. #: _____ Home Phone: (_____) _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ How long there? _____
Work: (_____) _____ Occupation: _____

SPOUSE / EMERGENCY CONTACT INFORMATION

Name: _____Relation: _____ Birth Date:_____
Address: _____ Phone: (_____) _____
Employer: _____ Work Phone: (_____) _____ ext._____

DENTAL BENEFIT INFORMATION

Primary Insurance
Insurance Co. Name: _____ Phone: (_____) _____
Policy # and Group #: _____ Insured's Employer: _____
Insured's Name: _____ Insured's Birth Date: _____
Relation: _____ Insured's Social Security #: _____

MEDICAL HISTORY

Patient Name: _____ Date: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is 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? [ ] Yes [ ] No If yes: _____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No If yes: _____

Have you ever had a serious head/ neck injury? [ ] Yes [ ] No If yes: _____

Are you taking any medications, pills, or drugs? [ ] Yes [ ] No If yes: _____

_____

Have you ever taken Bisphosphonates (Prolia, Fosomax, Actonel, Zometa, Aredia, Boniva, Reclast)?

[ ] Yes [ ] No If yes: _____

Have you ever been diagnosed with Osteoporosis/Osteonecrosis? [ ] Yes [ ] No If yes: _____

Do you use tobacco? [ ] Yes [ ] No If yes: _____

WOMEN: Are you…

[ ] Pregnant/Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives?

Have you informed your OB/GYN of your dental appointment?

[ ] Yes [ ] No Name/phone number of OB/GYN: _____

Are you allergic to any of the following?

[ ] Acrylic [ ] Iodine [ ] Metal [ ] Sulfa Drugs

[ ] Aspirin [ ] Latex [ ] Amoxicillin/Penicillin [ ] Other: _____

[ ] Codeine [ ] Local Anesthetics

Do you use controlled substances? [ ] Yes [ ] No If yes: _____

Do you have any of the following?

Acid Reflux	[ ] Yes [ ] No	Emphysema/COPD	[ ] Yes [ ] No	High Blood Pressure	[ ] Yes [ ] No	Respiratory Problems	[ ] Yes [ ] No
Allergies/Hay fever	[ ] Yes [ ] No	Epilepsy/Seizures	[ ] Yes [ ] No	High Cholesterol	[ ] Yes [ ] No	Rheumatic Fever	[ ] Yes [ ] No
Alzheimer's Disease	[ ] Yes [ ] No	Erectile Dysfunction	[ ] Yes [ ] No	HIV/AIDS Positive	[ ] Yes [ ] No	Rheumatism	[ ] Yes [ ] No
Anaphylaxis Reaction	[ ] Yes [ ] No	Excessive Bleeding	[ ] Yes [ ] No	Hives/Rash	[ ] Yes [ ] No	Sickle cell Disease	[ ] Yes [ ] No
Anemia	[ ] Yes [ ] No	Excessive Thirst	[ ] Yes [ ] No	Irregular Heartbeat	[ ] Yes [ ] No	Sinus Trouble	[ ] Yes [ ] No
Angina/Chest Pains	[ ] Yes [ ] No	Fainting/Dizzy Spells	[ ] Yes [ ] No	Kidney Problems	[ ] Yes [ ] No	Sleep Apnea	[ ] Yes [ ] No
Arthritis/Gout	[ ] Yes [ ] No	Frequent Cough	[ ] Yes [ ] No	Leukemia	[ ] Yes [ ] No	Stomach/Intestinal Problems	[ ] Yes [ ] No
Artificial Heart Valve	[ ] Yes [ ] No	Frequent Headaches	[ ] Yes [ ] No	Liver Disease	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No
Artificial Joint	[ ] Yes [ ] No	Glaucoma	[ ] Yes [ ] No	Low Blood Pressure	[ ] Yes [ ] No	Surgical Stent	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Heart Attack/Failure	[ ] Yes [ ] No	Lung Disease	[ ] Yes [ ] No	Thyroid Disorder	[ ] Yes [ ] No
Blood Disease	[ ] Yes [ ] No	Heart Disease (Congenital)	[ ] Yes [ ] No	Mental Disorders	[ ] Yes [ ] No	TMJ Disorder	[ ] Yes [ ] No
Breathing Problems	[ ] Yes [ ] No	Heart Murmur	[ ] Yes [ ] No	Mitral Valve Prolapse	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No
Bruise Easily	[ ] Yes [ ] No	Heart Pacemaker	[ ] Yes [ ] No	Osteoporosis	[ ] Yes [ ] No	Ulcers	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	Heart Trouble/Disease	[ ] Yes [ ] No	Pain in Jaw Joints	[ ] Yes [ ] No	Venereal Disease/STD	[ ] Yes [ ] No
Chemotherapy	[ ] Yes [ ] No	Hemophilia	[ ] Yes [ ] No	Radiation Treatment	[ ] Yes [ ] No	Yellow Jaundice	[ ] Yes [ ] No
Cold Sores/Fever Blisters	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No	Recent Weight Loss	[ ] Yes [ ] No		
Diabetes	[ ] Yes [ ] No	Herpes	[ ] Yes [ ] No	Renal Dialysis	[ ] Yes [ ] No		

Do you have any health problems/conditions that were not listed above or need further clarification?

[ ] Yes [ ] No If yes: _____

_____

Patient Signature Date

_____

Doctor Signature Date

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment is **due in full the day of treatment**, or on **pre-op visits** for extensive treatment appointments. Should a patient have dental insurance with assignment to Dr. Tran, the ***estimated*** patient portion will be the amount due. Any discrepancies with insurance eligibility and/or benefits will be the patient's responsibility to pay the balance. Insurance payments without assignment will be sent to the insured with payment due in full. The insurance plan is **YOURS**, as a courtesy, our office will help file any insurance claims. Hence, it is your responsibility to inform us of any changes **prior** to your dental visits. Our office has no leverage for payments; **you are ultimately responsible for all payments when service is rendered.** In addition, we have a 48 hours cancellation policy. We reserve the right to charge for any broken, no show and cancelled appointments without a minimum notice of 48 hrs.

Payment Options

1. For your convenience we accept Cash, Visa, MasterCard, American Express, Discover, & Check.
2. We also offer short and long-term financing options. (Interest-free options may apply- Care Credit)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor, is the responsible party for all dental services provided. Dental insurance in most cases is ***only a benefit with limitations*** and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you, as best we can, during your appointment. Please ask us if you have any questions.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- Failure to make a payment for more than 90 days may result in the patient account being turned over to a collection agency. Patient and/or legal guardian will be responsible for any collection fees involved.
- Returned checks are subject to a minimum of $40 accounting fee.

CANCELLATION AND BROKEN APPOINTMENT POLICY

We consider the time set aside for your appointment to be your reserved time. Consequently, when you do not provide us with a 48 hour courtesy call or email, our other patients waiting for an open appointment are affected. In order to allow all of our patients to experience the best available arrangements, please be aware of our Cancellation and No Show Policies and associated fees.

Please remember that you are a valuable member of our dental practice. This policy is constructed to better serve all of our patients, and we thank you for your cooperation.

Please cancel within normal business hours with at least 48 hours notice: Cancellations are only recognized when called or emailed during normal business hours. Please be certain that you have cancelled at least 48 hours prior to your appointment. One of our team members will gladly speak with you regarding scheduling, as **we do not accept cancellations through our answering system**.

Emergencies: We understand that true emergencies do arise. Appointments missed by an individual due to reasons beyond his/her control will be taken under careful consideration.

I have read this policy and asked any questions I may have. I understand that, if I do not cancel within the 48 hour notice period, I will be subject to a cancellation fee.

_____

Patient Name

_____

Patient Signature Date

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination and x-rays by Dr. Toan Tran and his associates. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Toan Tran to release any information regarding my dental/medical history, diagnosis and/or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Toan Tran, Mangrove Bay Dentistry P.A.

Photography Release

I authorize Dr. Toan Tran and/or his associates to take intra-oral and extra-oral photographs of me to help me better understand my current dental condition and possible treatment options.
I authorize Dr. Toan Tran to show dental photographs and x-rays, excluding self-portraits, to other patients to better explain their treatment options with the understanding that personal information (ie: name) will NOT be disclosed.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information/HIPPA.**

HIPPA RELEASE OF INFORMATION

[ ] I authorize the release of information including scheduling, appointment reminders, diagnosis, treatment, and records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call: [ ] My Home [ ] My Work [ ] My Cell

The best time to reach me is (day) _____ between (time) _____

May we text you regarding your appointment? [ ] Yes [ ] No

May we email you regarding your appointment? [ ] Yes [ ] No

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have read/received a copy of this practice's Notice of Privacy Practices (HIPAA).
I understand that I may ask any questions I might have regarding this notice.

_____

Patient and/or Legal Guardian Signature Date