PATIENT INFORMATION

Today's Date:_____ **Referred by:**_____

First Name:_____ **MI:**_____ **Last Name:**_____

Date of Birth:_____/_____/_____

SSN:_____-_____-_____ **Driver License ID: #** _____

Gender:_____ **Status (circle):** Married Single Child Other

Patient's Employer: _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Home Ph#:_____ **Work:**_____ **Cell#:**_____

Person to contact in case of emergency: _____ **Phone #** _____

Name of Person responsible for this Account: _____

Relationship to Patien: _____

I am myself / the parent / legal guardian / conservator of the patient. I agree to be responsible for all charges for the all services provided to the patient.

Name of the applicator:_____

Signature of Patient/applicator:

_____

_____

FOR DOCTOR ONLY

_____

_____

_____

_____

_____

_____

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_____

OC PROSTHODONTICS DENTAL PRACTICE
JENNY LE, D.D.S. - PROSTHODONTIST
9900 McFadden Ave, Ste 204, Westminster, CA 92683 | (714) 852-3357

Dental Record Number_____
Patient Name (Last, First, MI)
_____
Date of Birth (MM/DD/YYYY)_____

Medical and Dental Questionnaire

Mark your response to indicate if you have had any of the following diseases or problems.
Mark **don't know (DK)** if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

	Yes	No	DK
Do you have tuberculosis?	☐	☐	☐
Are you pregnant?	☐	☐	☐

Date of last physical examination: _____

Yes	No	DK	
☐	☐	☐	Any changes in your health within the past year?

Yes	No	DK	**Cardiovascular**
☐	☐	☐	High blood pressure
☐	☐	☐	Angina (chest pain)
☐	☐	☐	Heart attack
☐	☐	☐	Irregular heart beat
☐	☐	☐	Heart surgery
☐	☐	☐	Heart failure
☐	☐	☐	Damaged heart valve
☐	☐	☐	High cholesterol
☐	☐	☐	Heart infection
☐	☐	☐	Stroke

Yes	No	DK	**Hematologic**
☐	☐	☐	Anemia
☐	☐	☐	Sickle cell anemia
☐	☐	☐	Abnormal bleeding

Yes	No	DK	**Respiratory**
☐	☐	☐	Asthma
☐	☐	☐	Emphysema/bronchitis
☐	☐	☐	Sleep apnea
☐	☐	☐	Difficulty breathing

Yes	No	DK	**Endocrine**
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid problem

Yes	No	DK	**Renal**
☐	☐	☐	Kidney disorder
☐	☐	☐	Dialysis

Yes	No	DK	**Immune**
☐	☐	☐	Past use of steroids
☐	☐	☐	Delayed healing

Yes	No	DK	**Musculoskeletal**
☐	☐	☐	Arthritis
☐	☐	☐	Artificial joint
☐	☐	☐	Fibromyalgia
☐	☐	☐	Lupus
☐	☐	☐	Sjogren's Syndrome
☐	☐	☐	Osteoporosis

Yes	No	DK	**Gastrointestinal**
☐	☐	☐	Acid reflux/GERD
☐	☐	☐	Irritable bowel syndrome
☐	☐	☐	Stomach ulcer

Yes	No	DK	**Hepatic**
☐	☐	☐	Liver disease
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis

Yes	No	DK	**Neurologic**
☐	☐	☐	Epilepsy/seizures
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Headaches

Yes	No	DK	**Skin**
☐	☐	☐	Hives or skin rash
☐	☐	☐	Other skin lesions

Yes	No	DK	**Eyes/Ears**
☐	☐	☐	Glaucoma
☐	☐	☐	Impaired vision
☐	☐	☐	Impaired hearing

Yes	No	DK	**Mental Health**
☐	☐	☐	Bipolar disorder
☐	☐	☐	Depression
☐	☐	☐	Anxiety
☐	☐	☐	Eating disorders
☐	☐	☐	Sleep disorder
☐	☐	☐	Dementia
☐	☐	☐	Learning disorders

Yes	No	DK	**Infections**
☐	☐	☐	HIV positive/AIDS
☐	☐	☐	Sexually transmitted disease

Yes	No	DK	**Allergies**
☐	☐	☐	Local anesthetic
☐	☐	☐	Antibiotics
☐	☐	☐	Aspirin/ibuprofen
☐	☐	☐	Acetaminophen (Tylenol)
☐	☐	☐	Codeine/narcotics
☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Other:_____

Yes	No	DK	**Other**
☐	☐	☐	Cancer
☐	☐	☐	Cancer treatment
☐	☐	☐	Nursing infant
☐	☐	☐	Tobacco use
☐	☐	☐	Alcohol use
☐	☐	☐	Chemical dependency
☐	☐	☐	Street/recreational/ illicit drug use

Please list any disease, condition, or problem you have that is not listed above.

_____

_____

Please list any hospitalizations or surgeries you have had.

_____

(Please continue on opposite side)

Dental Information

Yes	No	
☐	☐	Is it important for you to keep your teeth?
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Does food frequently get caught between teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed loosening of your teeth?
☐	☐	Have you injured your head, neck, or jaw?
☐	☐	Do you have difficulty eating or swallowing?
☐	☐	Do you have a dry mouth?
☐	☐	Have you had a change in your ability to taste foods?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum treatment?
☐	☐	Your bite adjusted?
☐	☐	A bite plane/guard or other appliance?

Yes	No	Do you currently have:
☐	☐	Dental pain?
☐	☐	Sores or swellings in your mouth?
☐	☐	A partial/full denture or dental implants?
☐	☐	Do you supplement your diet with fluoride?
☐	☐	Have you had any difficulty with dental treatment?

Date of last dental x-rays_____
How often do you brush your teeth? _____
How often do you floss?_____
Date of last dental treatment:_____
Date of last teeth cleaning:_____

Reason for today's dental visit?_____

Please explain if you answered "Yes" to, or are uncertain about, any of the above items.

_____
_____
_____
_____
_____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____
Signature – Patient (or parent/guardian if patient is under 18) **Date**

****

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	Doctor Initial
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	

Dental Record Number___________
Patient Name (Last, First, MI) ___________
Date of Birth(MM/DD/YYYY)___________

Medication List

For use by dentist

Patient to fill out

Medication & Dose	Condition prescribed for	MM/YYYY started	Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
			Date/Change	Date/Change	Date/Change

INSURANCE PATIENT

1. I agree to be responsible for the fees charged for services provided to me(or the patient) by Dr. Jenny K. Le, if any part is not covered by my insurance.

2. I authorize Dr. Le to bill my insurance for her services, and agree to have my insurance pay her directly. If I receive any insurance payment by mistake, I agree to notify and forward the payment to Dr. Le.

3. I understand that Dr. Le cannot rely on the accuracy of any information obtained from my insurance company prior to my appointment. Therefore , she can only provide an estimate of my insurance payment and co-payment. If the estimate is less than what I owe, I agree to pay the amount owed when I receive Dr. Le's bill.

4. I understand that Dr. Le cannot waive the deductible and co-payment required by my Insurance. I agree to pay my deductible and estimated co-payment at the time of service.

5. I understand that my co-payment is the difference between what Dr. Le charges and What my insurance company pays. For example, if my insurance pays 80%, I understand it means that my insurance pays 80% of the fee it allows, not 80% of Dr. Le's fee.

6. I understand that my insurance will take about 1 to 2 months , or sometimes longer to process the claim Dr. Le submits for me.

7. I understand that my insurance will send me a copy of their payment to Dr. Le. If my Estimated co-payment was lower than the actual amount. I agree to pay Dr. Le the Additional amount I owe. If the estimate was high , I understand that she'll reimburse me for the difference.

8. I agree that Dr. Le can recover her collection fee and legal expenses from me if I do not pay as agreed above.

Dated:_____ _____

Patient/Guardian/Conservator of Patient

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fess for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____	_____	_____
Signature of patient or authorized responsible party	Relationship	Date

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to sign for patient (check one):

____Parent _____Guardian ____ Power of Attorney _____ Other

Please Note: It is your right to refuse to sign this Acknowledgment.

_____
Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____ An emergency prevented us from obtaining acknowledgement.

____ A communication barrier prevented us from obtaining acknowledgement.

____ The individual was unwilling to sign.

____ Other:

_____

_____

Staff Member Signature Date