TODAYS DATE: _____ / _____ / _____

Bothell DENTAL CARE est. 1954

Tien-Dat Nguyen DDS

PATIENT INFORMATION

PATIENT NAME: _____ Date of Birth: ____ /____ /____
PATIENT PHONE: _____PATIENT EMAIL:_____
PATIENT ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

How did you hear about our office? _____ ☐ I'm an established patient

PLEASE CIRCLE YOUR ANSWER

Are you apprehensive about dental treatment?	YES	NO
Have you had any complications following dental treatment?	YES	NO
Are you happy with the appearance of your teeth?	YES	NO
Do you want your teeth to be whiter?	YES	NO
Are you under a physician's care now?	YES	NO

PHYSICIANS NAME: _____
PHYSICIANS PHONE #: _____
PHYSICIANS OFFICE/LOCATION: _____
Have you been hospitalized, had surgery, a stroke or heart attack within the last six months? YES NO

Although dental personnel primarily treat the area in and around your 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. Please be as thorough and honest while answering the following questions.

Do you have any allergies? PLEASE **CIRCLE** or fill in OTHER:

Aspirin Penicillin Codeine Acrylic Metals Local Anesthetics LATEX

Sulfa Drugs Shellfish OTHER: _____

Do you currently smoke, use tobacco products or recreational drugs (including chewing tobacco, e-cigs, vaping, marijuana, other drugs)? **YES NO** If yes, please list: _____
If not currently using tobacco but have in your past, please list type (ex: cigarettes, chewing tobacco) and estimated length of years and estimated year you quit. _____
Have you had any serious or major hospitalizations or surgeries? **YES NO**

If yes, please list the **TYPE** and **YEAR**:

_____

_____

PLEASE CONTINUE ON THE BACK OF THIS PAGE

TODAYS DATE: _____ / _____ / _____

WOMEN: Are you …

Pregnant or trying to get pregnant? YES NO **Nursing?** YES NO

Taking oral contraceptives or on any birth control? YES NO
If yes, please state type and name: _____

Please list any medications, herbal supplements & vitamins you are taking. If you have an updated printed list, we can take a copy of that. Please list all below & the condition they are used to treat.

_____

_____

_____

Are you on a special diet currently? YES NO If yes, please briefly describe:

_____

Please check any of the following conditions that currently or previously have applied to you:

- ☐ Acid Reflux
- ☐ AID/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bells' Palsy
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bleeding Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ COPD
- ☐ Cortisone Medication
- ☐ DIABETES TYPE I / II (circle) LAST A1C DATE & NUMBER: _____ LAST BLOOD GLUCOSE CHECK DATE & NUMBER: _____
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Diarrhea /Constipation
- ☐ Headaches/Migraines
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints/Popping
- ☐ Parathyroid Disease
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you had your wisdom teeth removed? Y N

Do you wear removables such as CPAP, partials, retainers, etc? Y N

Have you had braces or orthodontics? Y N

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate drugs? Y N

TODAYS DATE: _____ / _____ / _____

ACKKNOWLEDGEMENT & CONSENT

Health History

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the healthy history questionnaire fully and accurately to the best of my ability.

Release of Information

I understand that the dentist may I understand that the dentist may need to collaborate with other healthcare providers and/or third-party payors in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of dental care to third-party payors and/or other health care providers related to my care.

Financial Policies

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies.

I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay.

I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that I am expected to pay what is due for my treatment when I receive it on the service date.

I understand that when a child of divorced parents is seen, whichever parent accompanies the child to their visit will be expected to pay.

I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within 15 days of receiving this statement. A late fee of 18% of total balance or $25.00 (whichever is greater) will be applied to balances over 30 days.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency. If legal action is commenced, the venue will be placed in Snohomish County, WA.

I understand that my account will be charged a $50 fee for any dishonored check, and that I am expected to pick up the check and pay the balance and subsequent fees in cash.

I understand that these policies may be superseded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling/Cancellation Policies

I understand that if I need to reschedule an appointment, or cannot make an appointment, I must give 48 hours notice to a staff member. If I do not give adequate notice, my account may be charged a $50 cancellation fee.

I understand that if I fail or cancel more than three appointments without appropriate notice, my active patient status will be reduced to emergency status, and I will be advised to seek an alternate dental provider outside of the office.

Privacy Practices

_____ initial I acknowledge receipt of Privacy Practices Notice (HIPPA) or that I have read over it, clearly understood and agreed.

Signature of patient (or parent/guardian if a minor) _____

Printed Name of patient (or parent/guardian if a minor) _____

Preferred method of contact for appointment reminder.

Phone _____ *Text* _____ *E-Mail* _____

Names and relationship of others we may share your information with in case of emergency & or for questions about your account finances, treatments, appointments.

_____

_____