Patient Dental History

Patient's Name: _____ Date: _____

Family Physician: _____ Phone # _____
Previous Dentist: _____ Phone # _____

How is your health? (Pleases circle one) Excellent Good Fair Poor

Do you have, or have you had any of the following? (Please circle all that apply.)

AID/HIV	Diabetes	Hepatitis A	Renal Dialysis
Alcoholism	Drug Addiction	Hepatitis B or C	Rheumatic Fever
Alzheimer's Disease	Easily Winded	Herpes	Rheumatism
Anaphylaxis	Emphysema	High Blood Pressure	Scarlet Fever
Anemia	Epilepsy/Seizures	Hives or Rash	Shingles
Angina Pectoris	Excessive Bleeding	Hypoglycemia	Sickle Cell Disease
Arthritis/Gout	Excessive Thirst	Irregular Heartbeat	Sinus Trouble
Artificial Heart Valve	Fainting/Dizzy Spells	Kidney Problems	Sleep Apnea/problems sleeping
Artificial Joint	Frequent Cough	Leukemia	Spina Bifida
Asthma	Frequent Diarrhea	Liver Disease	Stomach/Intestinal Disease
Blood Disease	Glaucoma	Low Blood Pressure	Stroke
Blood Transfusion	Hay Fever	Lung Disease	Swelling of Limbs
Bruise Easily	Headaches/Migraines	Mitral Valve Prolapse	Thyroid Disease
Cancer	Hearing Problems/Loss	Neck, Head or Back Pain	Tonsillitis
Chemotherapy	Heart Attack/Failure	Osteoporosis	Tuberculosis
Chest Pains	Heart Murmur	Pacemaker	Tumors or Growths
Cold Sores	Heart Trouble/Disease	Pain in Jaw Joints	Ulcers
Congenital Heart Disorder	Heart Stint	Parathyroid Disease	Venereal Disease
Convulsions	Heart Surgery	Psychiatric Treatment	X-Ray/Radiation Tx
Cortisone Medication	Hemophilia	Recent Weight Loss	Yellow Jaundice

Any other illness/surgeries? _____

Please answer the questions accordingly.

If you could change one thing about your smile, what would it be? _____
What have you liked most about any dental office you have been at before? _____
What have you liked the least? _____
Do you feel nervous about dental treatment? _____ YES / NO
Have you ever been upset about dental work you have received? _____ YES / NO
When were your last dental x-rays? _____
Do you have any unhealed injuries or inflamed areas in or around your mouth? _____ YES / NO
Have you experienced any growth or sore spots in or around your mouth? _____ YES / NO
Have you ever had any reaction or allergic reaction to local anesthetic? _____ YES / NO
Have you had any difficult extractions in the past? _____ YES / NO
If Yes, did you have any prolonged bleeding following the extraction? _____ YES/ NO
Do your gums bleed? _____ YES / NO
Do you chew on one side of your mouth? _____ YES / NO
If Yes, please indicate why. _____
Do you habitually clench or grind your teeth during the day or night? _____ YES / NO
Is any part of your mouth sensitive to pressures, hot, or cold, etc? _____ YES / NO
Have you ever had Orthodontic Treatment (Braces)? _____ YES / NO
Are you currently under the care of a physician? _____ YES / NO
Have you been a patient of the hospital during the last two years? _____ YES / NO
Have you ever had a serious head or neck injury? _____ YES / NO
Do you take, or have you taken, Phen-Fen or Redux? _____ YES / NO
Are you on a special diet? _____ YES / NO
Do you use tobacco products? _____ YES / NO
Do you use controlled substances? _____ YES / NO
Are you allergic to any medications? _____ YES / NO
If Yes, please specify. _____
Are you currently taking any medications? _____ YES / NO
If Yes, please specify. _____
_____
_____

Women: Are you… Pregnant? YES / NO Taking Oral Contraceptives? YES / NO Nursing? YES / NO

Thank You for Selecting Our Dental Team

Patient Information (CONFIDENTIAL) Date: _____

Name: _____ Birthday: _____ SSN_____

Sex: Male / Female Height_____ Weight_____ Marital Status: M S D W

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Patient Employer/School: _____ Work Phone: _____
may we contact you at this Number? Y/N

Business/School Address: _____ City: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone_____

Person to Contact In Case Of Emergency: _____ Phone: _____

Nearest Friend/Relative not living with you: _____ Phone: _____

Whom May We Thank for Referring You? (Please circle)

Val-Pak Yellow Pages/yellowpages.com Newspaper Ad (which paper?) Internet (which site?)

Friend/Family: _____ Other_____

Responsible Party

Name of Person Responsible for the Account: _____ Relationship to patient _____

Address: _____ SSN: _____ Home Phone: _____

Birthday: _____ Employer: _____ Work Phone: _____ Current Patient?
May we contact you at this number? Y / N Yes NO

Insurance Information

Name of Insured: _____ Relationship to patient _____

Birthday: _____ SSN: _____ Date Employed: _____ Work Phone: _____

Name of Employer: _____ Address of Employer: _____

Insurance Company: _____ Group#_____ Union or Local#_____

Insurance Company Phone #: _____ Address: _____

I authorize the assignment of my insurance benefits to Dr. Colleen Nguyen, D.D.S., P.A.

Signature: _____ Date: _____

Do you have Any Additional Insurance Information? YES / NO If Yes Complete the Following.

Name of Insured: _____ Relationship to patient _____

Birthday: _____ SSN: _____ Date Employed: _____ Work Phone: _____

Name of Employer: _____ Address of Employer: _____

Insurance Company: _____ Group#_____ Union or Local#_____

Insurance Company Phone #: _____ Address: _____

Colleen Nguyen, D.D.S., P.A.
Deedra Truschinger, D.D.S.

DENTISTRY

9501 State Ave., Ste. #7
Kansas City, KS 66111

WELCOME TO OUR DENTAL TEAM!!! We are looking forward to meeting you and caring for your dental health. We thank you for selecting us as your personal dental care team, and we strive to make you relationship with our office a pleasant one. We believe that service to our patients is at its best when there is complete understanding and mutual cooperation. We have established the following guidelines to help achieve these goals:

All insurance filing is strictly done as a courtesy. By providing us with your complete insurance information, it will help us expedite insurance processing. Kansas law requires your insurance to pay within 30 days of filing. Insurance claims not paid within 45 days will become the responsibility of the patient. Any and all services provided are the patient's responsibility. A 1.5% finance charge will be added to all balances over 30 days past due.

ALL FEES AND/OR CO-INSURANCE IS DUE AT THE TIME OF SERVICE.

As a courtesy to our patients, we have several payment options. We accept CASH, CHECK or CREDIT CARD. VISA, MASTERCARD, and DISCOVER accepted. We also offer financing through Care Credit (with approved credit). Should I default, I agree to pay all fees of collection, including but not limited to Collection Agency fees up to 30% of the unpaid balance, court cost, and reasonable attorney fees, all of which may be paid or incurred by the holder of this note.
****Only patients will be allowed in the treatment rooms, in accordance with OSHA requirements.***

Cancellations: While we certainly understand your plans can change, the treatment you schedule is reserved especially for you. For individual services, a **24 hour cancellation notice is required** to avoid being charged a NO SHOW fee of $75.00*. 48 hours cancellation is preferred. The more notice we have the better chance we may fill the appointment slot. This allows others to enjoy our services.

Scheduling: ***If arrival is more than 15 minutes after scheduled appointment the services will be rescheduled or treatment will be reduced as a courtesy to other clients.** Please plan to arrive at least 15 minutes prior to your scheduled service to get checked in and prepare for your treatment. This allows time to update paperwork, verifying insurance and reviewing consents for treatment. At the time of booking, services will need to be secured with a credit card. At the time of booking, services will need to be secured with a credit card. Visa/Master/Discover accepted.

***A NO SHOW means $75.00 fee. Client account or credit card will be charged**.

It has always been our goal to provide the utmost in dental care and stand behind our work. As a courtesy, we do warranty all treatment, for a guaranteed period of time, as long as the patients are compliant with the preventative care maintenance that is recommended for that individual. This is necessary in order to maintain a health oral cavity and integrity of the restorations. The warranty is forfeited if any cleaning appointments are missed.
I consent to treatment as necessary or desirable for the diagnosis of dental disease, or treatment of dental emergency. These procedures may include radiographs, models and intraoral examinations. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give consent to the use of local anesthetic for completing the necessary dental treatment.
A misunderstanding can be an obstacle to forming a satisfactory relationship. If at any time you have a question please feel free to discuss it with us promptly and openly. We would greatly appreciate this.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE GUIDELINES.

_____ _____

Patient, Parent or Legal Guardian Date

Colleen Nguyen, D.D.S., P.A.
Deedra Clark, D.D.S.
9501 State Avenue, Suite 7

Kansas City, KS 66111
(913) 788-0800

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in the Notice while it is in effect. This Notice takes effect 4/14/2003, 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 changes are permitted by applicable law. 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 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us 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 you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use and disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonably 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.
Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $2.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 request.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternate means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. 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 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.
Contact Officer: Colleen Nguyen, D.D.S., P.A.
Telephone: 913-788-0800
e-mail: gentledentalkc@gmail.com
Address: 9501 State Avenue, Suite #7, Kansas City, Ks. 66111

Kansas City, KS 66111
(913) 788-0800

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practice.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice's, but acknowledgement could not be obtained because:

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

Colleen Nguyen, D.D.S., P.A.
Deedra Clark, D.D.S.
9501 State Avenue, Suite 7
Kansas City, KS 66111
913-788-0800

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____

Patient # _____ Social Security # _____

Section B: to the Patient – Please Read the Following Statements Carefully

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change out privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Colleen Nguyen, D.D.S., P.A.
Telephone: 913-788-0800
Address: 9501 State Avenue, Suite 7, Kansas City, Ks 66111

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include complete Consent on the patient's chart.