Christine Nguyen, DDS, PA

1330 S. Orlando Ave. Winter Park, FL 32789 Office (407) 629-4077 Fax (407)629-4431

Patient Registration Form

Patient Name: _____

Date of Birth: _____

SS #: _____

Driver's License: _____

Address: _____

City/State/Zip: _____

Cell: (_____)_____-_____

Home: (_____)_____-_____

Work: (_____)_____-_____

Email: _____

Emergency Contact: _____

Emergency Contact Phone: (_____)_____-_____

Referred By: _____

Name of Insured: _____

Insured SS#: _____

Insured DOB: _____

Relation to Patient: ____Spouse _____Parent ____Other

Employer: _____

Position Held: _____

How Long: _____

Ins. Company: _____

Plan Name: _____

Policy #: _____

Ins. Address: _____

City, State, Zip: _____

Ins. Phone: (_____)_____-_____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information given on this page.

Patient /Guardian's Signature: _____ Date: _____

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MED. ALERT

Medical History

Patient Name: _____

Are you under a Physician's care now: _____
Please Explain

Physician's Name: _____ Physician's Phone: _____

Medications List: _____ _____ _____ _____ _____ (cont. on back)

ALLERGIES: ___Penicillin ____Latex ___Codeine Other:_____

Do you have, or have you had, any of the following: (Please Check all that apply)

___AIDS/HIV Positive	**___Chest Pains**	**___Frequent headaches**	**___Irregular Heartbeat**	**___Scarlet Fever**
___Alzheimer's	**___Cold Sores**	**___Genital Herpes**	**___Kidney Problems**	**___Shingles**
___Anaphylaxis	**___Congenital Heart Disorder**	**___Glaucoma**	**___Leukemia**	**___Sickle Cell Disease**
___Anemia	**___Convulsions**	**___Hay Fever**	**___Liver Disease**	**___Sinus Trouble**
___Angina	**___Cortisone Medicines**	**___Heart Attack/Failure**	**___Low Blood Pressure**	**___Spina Bifida**
___Arthritis/Gout	**___Diabetes**	**___Heart Murmur**	**___Lung Disease**	**___Stomach Disease**
___Artificial Heart Valve	**___Drug Addiction**	**___Heart Pace Maker**	**___Mitral Valve Prolapse**	**___Stroke**
___Artificial Joint	**___Easily Winded**	**___Heart Trouble/Disease**	**___Pain in Jaw Joints**	**___Swelling of Limbs**
___Asthma	**___Emphysema**	**___Hemophilia**	**___Parathyroid Disease**	**___Thyroid Disease**
___Blood Disease	**___Epilepsy/Seizures**	**___Hepatitis A**	**___Psychiatric Care**	**___Tonsilitis**
___Blood Transfusion	**___Excessive Bleeding**	**___Hepatitis B or C**	**___Radiation Treatment**	**___Tuberculosis**
___Breathing Problem	**___Excessive Thirst**	**___Herpes**	**___Recent Weight Loss**	**___Tumors or Growths**
___Bruise Easily	**___Fainting Spells/Dizziness**	**___High Blood Pressure**	**___Renal Dialysis**	**___Ulcers**
___Cancer	**___Frequent Cough**	**___Hives/Rash**	**___Rheumatic Fever**	**___Venereal Disease**
___Chemotherapy	**___Frequent Diarrhea**	**___Hypoglycemia**	**___Rheumatism**	**___Yellow Jaundice**

Please explain all conditions checked: _____

_____

Please List/Discuss any condition(s) not listed: _____

_____

I Certify that All Information Provided is Complete and Accurate:

Patient/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

NOTES:

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Dental History

Previous Dentist Name: _____

Date of last dental visit: _____ Date of last dental cleaning: _____

Chief dental concern: _____

Unhappy with Appearance of Teeth: _____

Experiencing Dental pain/sensitivity: Explain: _____

Experiencing TMJ Pain/Discomfort: Explain: _____

Experiencing Clenching/Grinding/Snoring Explain: _____

Previous unpleasant dental experiences Explain: _____

Previous Incident with Extractions Explain: _____

Previous Incident with Local Anesthesia Explain: _____

Previous Incident with Healing Explain: _____

Interested in Whitening Yes/ No _____

Interested in Straightening teeth Yes/ No _____

Interested in Night Guard Yes/ No _____

Interested in Apnea/Snoring appliance Yes/ No _____

I Certify that All Information Provided is Complete and Accurate:

Patient/Guardian's Signature: _____ Date: _____

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Cancellation Policy:

We reserved time on our schedule to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment. Early notice allows us time to schedule other patients who may be waiting for this appointment time.

We require at least a 24 hour notice for any cancellation or changes to your appointment. A fee will be charged to your account for not honoring this policy.

$40 No-Show/Cancelling within 24-Hours for Appointments with Dr. Nguyen
$30 No-Show/Cancelling within 24-Hours for Hygiene/Cleaning Appointments

Patient/Guardian's Signature: _____ Date: _____

Financial Policy:

All patients are expected to pay by cash, check, or major credit card the day services are rendered. We do offer payment plans through Care Credit, Inc. with no or low interest rates.

For those patients who are covered by private insurance, we accept some assignment of benefits and file your insurance for you. Most dental plans have a deductible that the patient must pay before the dental coverage will begin. The patient must pay the percentage that is not covered by the insurance company before treatment is started. Please be aware that each insurance company uses varying and different standards to determine what they consider to be reasonable and customary charges for services rendered by a dentist. Our fee's may or may not be higher than what your insurance company considers to be reasonable and customary. All procedures that have co-payments will need to be paid the day of service. For crowns, bridges, partials and dentures, full payment is due the day the final impressions are taken and before being sent to the lab for final processing.

We will be glad to assist you in dealing with your insurance company, but the responsibility for payment is the patient's or their parent/guardian. If payment from the insurance company is not received within 30 days from the date of service, the balance will be due from the patient or their parent/guardian.

Any procedures that require lab expenses are non-refundable. For example: crowns, bridges, partials, dentures, veneers, implants, etc.

Our return check policy is as follows: If a check is returned for any reason you will be charged a return check fee of $25.00. This amount plus the amount of the check is due immediately upon notification. Only cash, credit card or money order will be accepted.

We reserve the right to place an account with a collection agency for any balances that remain unpaid after 60 days.

Patient/Guardian's Signature: _____ Date: _____

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Consent for Use and Disclosure of Protected Health Information (HIPAA) :

With my consent, Christine Nguyen, D.D.S., P.A. may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Christine Nguyen, D.D.S., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Christine Nguyen, D.D.S., P.A. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Christine Nguyen, D.D.S., P.A. Privacy Officer at 1330 S. Orlando Ave. Winter Park, FL 32789.

With my consent, Christine Nguyen, D.D.S., P.A. may call my home or other designated location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Christine Nguyen, D.D.S., P.A. may mail or e-mail to my home or other designated location and any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patients statements. I have the right to request that Christine Nguyen, D.D.S., P.A. restrict how its uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Christine Nguyen, D.D.S., P.A.'s use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Christine Nguyen, D.D.S., P.A. may decline to provide treatment to me.

Patient/Guardian's Signature: _____ Date:_____

Consent for Oral Examination and Diagnostic X-Rays:

I hereby authorize Dr. Christine Nguyen, D.D.S. and whomever she may designate as her assistants, to perform upon me the following procedures: Oral Examination and Diagnostic X-Rays

I request and authorize Dr. Nguyen to do whatever she deems advisable if any unforeseen condition arises in the course of these designated procedures calling in her judgment, for procedures in addition to, or different from those now contemplated.

I further consent to the administration of local anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case. I understand that there is an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, site discoloration, and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit prescribed diagnostic procedures.

Patient/Guardian's Signature: _____ Date:_____