Duluth Dental Associates, P.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT FOR USE AND DICLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____ ZIP CODE: _____

TELEPHONE: _____ DATE OF BIRTH: _____ SSN: _____

How did you hear about us ? (Google, Friend, Insurance, etc...)

_____

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 information to carry out treatment, payment activities, and healthcare options.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign the consent, out notice provides 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. **(Please ask for copy if you would like one for your records)** We encourage you 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 our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information we maintain.

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

- **Office Manager: Ali Ramirez**
- **Office number: 678-417-7709**
- **E-mail: Duluthdentalassociates@gmail.com**
- **Address: 3415-B Duluth Hwy 120, Duluth GA 30096**

Right to Revoke: You have the right to revoke the consent at any time by giving us a written notice of your revocation submitted to the office manager. Please understand that revocation of this consent 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 continue treating you if you revoke this consent.

I, _____, have had the 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 consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care options.

SIGNATURE: _____ DATE: _____

If this is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____ Relationship to patient _____

Duluth Dental Associates
Dr. Van Nguyen, D.M.D

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 Practices.
(Please ask for copy if you would like for your records)

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

Individual refused to sign
Communication barriers prohibited obtaining acknowledgement.
An emergency situation, prevented obtaining acknowledgement.
Other (Please Specify) –

_____

_____

_____

DULUTH DENTAL ASSOCIATES, PC FINANCIAL EXPLANATION

Payment is expected at the time treatment is rendered. We accept Cash, Checks, and most credit cards.

Insurance:

Professional services are rendered and **charged to you, not the insurance**. All deductibles and fee amounts not covered by insurance are due at the time of treatment unless written financial arrangements are made with the office manager prior to starting treatment. Our office will not dispute with your insurance over a claim. This is your responsibility and obligation. We will file your claim one time. You will receive a statement every month if your account shows a balance due. If at the end of 60 days after the date of service, your insurance has not paid, you then are responsible for your entire balance.

In order to honor any insurance benefits, you **MUST** provide insurance identification (i.e. insurance ID cards, benefit book, etc.) and we must be able to verify the current benefits available with each visit to our office.

Insurance negotiated fees and reimbursements may represent an agreed to fee schedule with your insurance provider that is different from our Usual and customary fee are part of your insurance benefit package. The amounts you are charged or reimbursed are subject to change at the discretion of your insurance company. We always provide the most recent fee schedules and reimbursement information available. Your portion can and may change based upon their actions.

Coordination of benefits:

If you have two forms of benefit coverage, we will consider your coverage as primary and your spouse's coverage as secondary. If your dependent has two plans, we will apply the insurance industry standard 'Birthday Rule' to determine the primary and secondary coverage.

Extended Payment Plan:

A third-party organization provides loans to patients for dental treatment. (i.e. Care Credit) A Patient must qualify for this type of arrangement. Applications are available online or by phone. Feel free to ask for more information.

Office Fees:

If you present a check with insufficient funds, or place a stop on an issued check you will be charged $35.00 fee for processing. If you have any questions regarding your accounts please do not hesitate to ask.

Broken Appointment Policy

Please consider your schedule carefully. We ask for a **48-Hour notice of cancellation**. If an appointment is not confirmed via phone, text or email within 48hours we reserve the right to give your time slot to another patient. If your appointment is confirmed and you do not show for your appointment there will be a **$25 charge for Hygiene appointments and $100 fee for appointments with the Dr.**

I have read and fully understand the statement outlined above.

SIGNED_____ DATE_____