IMPRESSION DENTAL P.C

Chart#
FOR OFFICE USE ONLY

PATIENT INFORMATION FORM (Please Print)

Today Date: _____ S.S.N # _____ Sex: ☐ Male ☐ Female

Patient Name: _____ Date of Birth: _____/_____/ ____
Last First Middle (Preferred Name) MM DD YY

Home Phone: (____) _____ Work: (_____) _____Ext _____ Cell: (_____) _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

If Patient is a minor, please give parent's or guardian's Name: _____ Relationship: _____

Whom may we thank for referring you to our practice: _____

In case of emergency, who should we contact? _____ Telephone: (____) _____

DENTAL HISTORY:

Date of Last Dental Exam: _____ Date of Last X-rays _____ Reason for Today's visit: _____
How often do you floss? ☐ None ☐ 1 time ☐ 2 or 3 times a day How often do you Brush? ☐1 time ☐ 2 times ☐ 3 or 4 times a day

Please check those that apply:

Bad Breath ..... ☐	Loose teeth or Broken Filling(s) ..... ☐	Sensitively to Sweets/Heat/Cold ..... ☐
Bleeding Gums ..... ☐	Orthodontic Treatment ..... ☐	Grinding Teeth ..... ☐
Blisters on Lips or Mouth , ☐	Pain around Ear ..... ☐	Periodontal Treatment (Gum..... ☐

Have you ever had any complications following dental treatment? .... ☐ YES .... ☐ NO

	YES	NO		YES	NO
Are you currently under medical treatment	☐	☐	Have you ever had any serious illnesses	☐	☐
Do you Smoke?	☐	☐	Do you use Alcohol?	☐	☐
Women: Are you pregnant? ☐ YES .. Due Date _____ ... ☐ NO			Are you currently taking any medication? .	☐	☐

☐ AID	☐ Cancer	☐ HIV	☐ Mental Disorders	☐ Shortness of Breath
☐ Anemia	☐ Diabetes	☐ High Cholesterol	☐ Nervous Disorders	☐ Stomach Problems
☐ Arthritis	☐ Dizziness	☐ High Blood Pressure	☐ Pacemaker	☐ Tuberculosis
☐ Artificial Heart Valves	☐ Jaundice	☐ Radiation Treatment	☐ Tumors	☐ Thyroid
☐ Asthma	☐ Fainting	☐ Heart Disease	☐ Respiratory Disease	☐ Ulcers
☐ Bleeding Abnormalities	☐ Glaucoma	☐ Kidney Disease	☐ Sinus Problems	☐ Stroke
☐ Blood Disease	☐ Hepatitis	☐ Liver Disease	**ALLERGY**: ☐ **Codeine**	☐ **Penicillin** ☐ **Latex**

Please list all medications you are taking: _____

_____ _____ _____ _____ _____

Are there any other health conditions you have that are not listed? ..... ☐ YES .... NO
if so, please explain: _____

EMPLOYER INFORMATION

Employer Name: _____ Employer Phone #: (____) _____

Employer Address: _____

Spouse's Name: _____S.S.N # _____ DOB : _____/ _____ / _____

Whom may we contact in the case of an emergency? _____ Phone # : _____

Who is responsible for this bill? _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ S.S.N # _____ Telephone # _____

Insurance company: _____ ID# _____ Group # : _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ S.S.N # _____ Telephone # _____

Insurance company: _____ ID# _____ Group # : _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

_____ _____

Signature of patient, or guardian. Date

IMPRESSION DENTAL P.C.

Steve Nguyen D.D.S
6167 Fuller Court
Alexandria, VA 22310
Tel: (703) 822-0670
Email: info@impressiondental.net

Financial Policy

This is an agreement between **IMPRESSION DENTAL P.C.** and the patient name on this form.

By this agreement, you are agreeing to pay for all services that are received.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges for services rendered but not covered by your plan or not paid (denied) by your insurance.

Require payments: Payment is required at the time you receive your dental treatment. If you have dental insurance coverage, we will *estimate* your insurance co-payments required by your insurance company and it must be paid at the time of service.

Statement: Should you end up with a balance on your account due to *underestimation* of your insurance co-payment, we will send you a statement. It will show the charges to the account. It will show the charges to the account, and any payments or credits applied to your account.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if payment is not received within 30 days.

Payment Options:

1. You may pay by cash or credit card on the day the treatment is rendered.
2. On treatment involving crown and bridgework, dentures, root canals, etc, that require longer than an hour appointment, you agree to put in a deposit of at least 50% of the dental fee or your co-insurance payment before and appointment date and time is reserved for you.
3. If you **pre-pay** an entire treatment plan or part of the proposed treatment plan by cash, or credit card (except financing) before you schedule your appointments, you will receive a one time 5% **bookkeeping discount** for the dental procedure(s)
4. We offer 6-12 months no interest financing for qualified patients through a third party Care Credit. They pay us your dental fees and if you pay them in full by the end of the promotion's term, they will not charge you interest.

Missed Appointment fee: If a patient cancels with less than 24 hours notice, a **$40** fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs.

Patient's Name: _____

Date of Birth: _____

Signature or Guardian: _____

Today Date: _____

IMPRESSION DENTAL P.C.

Steve Nguyen D.D.S
6167 Fuller Court
Alexandria, VA 22310
Tel: (703) 822-0670
Email: info@impressiondental.net

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize the dentist of **IMPRESSION DENTAL P.C.** and dental auxiliaries of his choice, to perform the following dental treatment of oral surgery procedure(s), including the use of any necessary or advisable local anesthesia.
    a. Preventive hygiene treatment (prophylaxis) and the application of fluoride.
    b. Application of plastic "sealant" to the groves of the teeth.
    c. Treatment of disease or injured teeth with dental restorations (filling/crown).
    d. Replacement of missing teeth with dental prosthesis (bridge, partial denture, and complete denture).
    e. Removal (extraction) of one or more teeth.
    f. Treatment of disease or injured oral tissues (hard and/or soft).
    g. Use of sedative drugs to control apprehension and/or disruptive behavior.
    h. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have the opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to use the use of local anesthesia.
4. I recognize that during the course risks of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being professional judgment of the dentist.
5. There are possible risks and complication associated with the administration of local anesthesia. The most common are swelling, bruising, tingling, numbness of the lips, gums, face, and tongue, allergic reaction, hematoma (swelling or bleeding at or near the injection site), fainting lips, and cheeks biting resulting ulceration and infection mucosa. I understand I have been informed of the above risks.
6. I am advised that the success of my dental treatment provided to me will require I follow post-operation and post-care instructions from the dentist. I agree to follow-up with regular office visits recommended by the dentist to ensure the success of my dental treatment.
7. I hereby state that I have read and understand this consent form, and that all questions, about the procedures will be answered in a satisfactory manner. I understand I have the right to be provided answers to questions, which may arise during and after the course of treatment.
8. I understand this consent form remain effect as long as I am and active patient with Dr Steve Nguyen.

Patient's Name: _____ Date: _____

Patient's Signature (if minor, parents or guardian): _____