Chart #: _____
FOR OFFICE USE ONLY

About You

Patient Name: _____ Date: _____
Last, First M (Preferred Name)

☐ Male ☐ Female ☐ Married/partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Birth Date: _____ DL#: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell /Other: _____

Home Address: _____
Street Apartment # City State Zip Code

Employer: _____ How long there? _____

Occupation: _____ Email Address: _____

Whom may we Thank for referring you? _____ Other family members seen by us: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Person Responsible for Account: _____

Spouse Information

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Employer: _____

Insurance Information

Primary : **Dental Coverage?** ☐ Yes ☐No

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary: **Dental Coverage?** ☐ Yes ☐No

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I here by authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Medical History

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name: _____ Phone # ( )_____ Date of last visit: _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
Do you smoke or use tobacco in any other form? ☐ Yes ☐ No
Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No
List of any medication taking_____
Have you ever taken Phen-Fen? Also know as Redux or Pondimin. ☐ Yes ☐ No If yes when? _____
For Woman: Are you using a prescribed method of birth control?
Are you pregnant? ☐ Yes ☐ No Week #_____. Are you nursing? ☐ Yes ☐ No
Have you ever had any of the following? Please check those that apply

Y N Abnormal Bleeding
Y N AIDS
Y N Alcohol / Drug Use
Y N Allergies _____
_____
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemo
Y N Colitis

Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/ Fever Blisters
Y N High Blood Pressure

Y N HIV
Y N Hospitalized for Any Reason
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures

Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problem
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease
Other
_____
_____

Are you allergic to any of the following?
Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Other: _____
Y N Jewelry/Metals Y N Tetracycline Y N Dental Anesthetics Y N Latex _____
Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____
Our Office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Smile History

Date of Last Dental Visit: _____ Reason for this visit: _____
Are you currently in pain? ☐ Yes ☐ No Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Your Current dental health is: ☐ Good ☐ Fair ☐ Poor
On a scale of 1 to 10, where would you rate your fear of dentistry? _____
Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No
Have you been given good home care instructions in the past? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No
Have you ever had gum treatment? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No
Have you ever had orthodontic treatment? ☐ Yes ☐ No
How long has it been since you've had x-rays? _____ How often do you usually have you teeth cleaned? _____
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Are your teeth sensitive to heat ☐ Y ☐ N, cold ☐ Y ☐ N, or anything else? _____
When you chew your food, do you tend to favor one side? ☐ Yes ☐ No. If Yes, ☐ Left ☐ Right
Are you concerned about the old Mercury containing fillings and want to know your option to replace them? ☐ Yes ☐ No
Do you have any loose teeth? ☐ Yes ☐ No Do you still have wisdom teeth? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No If not, what would you change?
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

When an appointment is made for your visit, we reserve a time slot specifically for you. **If you can not keep your appointment, please kindly give 48 hours notice. A cancellation without 48 hours advance notice or a no show for appointment will be charged $150.00 for appointment with the doctor and $100.00 for appointment with hygienist.**

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian
Relationship to Patient: _____

_____ Date: _____
Signature of guarantor of payment/responsible party
Relationship to Patient: _____

VICKIE Y. GE, D.D.S.
113 WATERWORKS STE. 145
IRVINE, CA 92618

949-551-6868

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received from Dr. Vickie Ge a copy of the Dental Materials Fact Sheet.

Patient Signature_____

Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

VICKIE Y. GE, D.D.S.
113 WATERWORKS STE. 145
IRVINE, CA 92618

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the **Health Insurance portability & Accountability Act of 1996 (HIPPA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the Notice of Privacy practices and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Date: _____
Signature: _____

Dependent family members also covered by this acknowledgement:

_____

_____

. . . . . .

For office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- The patient refused to sign
- Communication barrier
- Emergency situation
- Other