Patient Name: ______________________________ Date: ________
Last, First MI (Preferred Name)

Address: ______________________________
Street Apartment #

____
City State Zip Code

Home Phone: ____________ (Work): ____________ Ext: ______ Cellular Phone: ____________

Best phone number to reach you at: ____________ email: ____________

I agree to information by email: ______________________________

Social Security #: ____________ Drivers License #: ____________ Birth Date: ____________ Gender: ____

Responsible Party if Different from Patient Information

Name: ______________________________ Relationship to patient: ____________
Last, First MI (Preferred Name)

Address: ______________________________
Street Apartment #

____
City State Zip Code

Home Phone: ____________ (Work): ____________ Ext: ______ Cellular Phone: ____________

Best phone number to reach you at: ____________ email: ____________

Can we send information by email? ______________________________

Social Security #: ____________ Drivers License #: ____________ Birth Date: ____ Gender: ____________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City, State Zip Code

Insurance Information

Primary Insurance Company: ______________________ Group Plan Name: ____________

Name of Insured: ______________________________
Last First MI

Insured's Birth Date: ________ Social Security # ____________ ID # or 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 ____________

Secondary Insurance Company: ______________________ Group Plan Name: ____________

Name of Insured: ______________________________
Last First MI

Insured's Birth Date: ________ Social Security # ____________ ID # or 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, explain: ____________

How did you hear about our office? ______________________________

Whom may we thank for referring you to our practice? ______________________________

Have you ever had any of the following? Please check yes or no:

Y N	Condition	Y N	Condition	Y N	Condition	Y N	Condition
☐☐	AIDS	☐☐	Dizziness	☐☐	High Cholesterol	☐☐	Rheumatic Fever
☐☐	Allergies	☐☐	Drug/Alcohol Problem	☐☐	Hip Surgery	☐☐	Rheumatism
☐☐	Amoxicillin Allergy	☐☐	Emphysema	☐☐	Jaundice	☐☐	Seizures
☐☐	Anemia	☐☐	Epilepsy	☐☐	Kidney Disease	☐☐	Sinus Problems
☐☐	Anesthetic Allergies	☐☐	Erythromycin Allergy	☐☐	Latex Allergy	☐☐	Stomach Problems
☐☐	Arthritis	☐☐	Excessive Bleeding	☐☐	Liver Disease	☐☐	Stroke
☐☐	Artificial Joints	☐☐	Fainting	☐☐	Mental Disorders	☐☐	Sulfa Allergy
☐☐	Aspirin Allergy	☐☐	Glaucoma	☐☐	Migraine Headaches	☐☐	Tetracycline Allergy
☐☐	Asthma	☐☐	Growths	☐☐	Mitral Valve Prolapse	☐☐	Thyroid Problems
☐☐	Blood Disease	☐☐	Hay Fever	☐☐	Nervous Disorders	☐☐	TMJ problems
☐☐	Cancer	☐☐	Head Injuries	☐☐	Pacemaker	☐☐	Tremors
☐☐	Cerebral Palsy	☐☐	Heart Disease	☐☐	Penicillin Allergy	☐☐	Tuberculosis
☐☐	Chemotherapy/ Radiation therapy	☐☐	Heart Murmur	☐☐	Pre Med needed	☐☐	Tumors
		☐☐	Hepatitis	☐☐	Pregnant now Due date:__________	☐☐	Ulcers
☐☐	Codeine Allergy	☐☐	High Blood Pressure	☐☐	Radiation Treatment	☐☐	Venereal Disease
☐☐	Diabetes	☐☐	Low Blood Pressure	☐☐	Respiratory Problems	☐☐	Vicodin Allergy

OTHER HEALTH ISSUES NOT LISTED: **MEDICATIONS:**

____

____

____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ____________________
- Have you ever taken prescription medications for weight loss (diet Pills)? ☐ Yes ☐ No
  If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
- Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

Dental Background Information:

Have you had or do you have any of the following:

Y N	Condition	Y N	Condition	Y N	Condition
☐☐	Bleeding Gums	☐☐	Difficulty Getting Numb	☐☐	Clicking or Popping Jaw
☐☐	Periodontal Problems	☐☐	Difficulty chewing	☐☐	Jaw Pain
☐☐	Loose Teeth	☐☐	Sensitivity to Hot or Cold	☐☐	Clench or Grind Teeth

How often do you brush your teeth? ____________________ How often do you floss your teeth? ____________________

Have you ever considered whitening or straightening your teeth? ______________________________________

Agreement for Services, Payments and Insurance Assignment and Release for Benefits

I understand that I am financially responsible for all charges incurred by me or my dependents and agree to pay for all charges not covered by my insurance company. 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. By consenting to treatment, I acknowledge financial responsibility for completed work.

I hereby assign my insurance benefits directly to Dr. Jon Vongschanphen and authorize the release of information necessary to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

Patient Payments are collected on the day services are rendered. As a condition of your treatment by this office, financial arrangements must be made in advance. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 or my dental treatment.

The highest level of care and quality is placed in providing our patients with the best that dentistry has to offer. Unfortunately, we are unable to predict the longevity of any dental restorations. This is particularly true if there is a history of clenching, grinding, TMJ, broken crowns, and fillings.

To the best of my knowledge, I hereby certify that the above personal and insurance information is correct. I have read the above conditions of treatment and payment and agree to their content.

____ ____

Signature of patient, parent or guardian Relationship to Patient

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

____ ____________________

Signature of patient, parent or guardian Date

Appointment Appreciation Policy

We require TWO BUSINESS DAYS notice to change or cancel your appointment. We reserve the right to charge up to $250 for any appointments that are missed or cancelled with less than two business days notice. We understand that things do come up at the last minute from time to time and we will always take that into consideration.

We are respectful of your time and appreciate that you respect the time you reserve for your appointments with us.

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

____ ____________ ______________________________

Signature of patient, parent or guardian Date Relationship to Patient

I have received a copy of the Dental Board of California's Dental Materials Fact Sheet:

____________________________________ ____

Signature of patient, parent or guardian Date

I have received a copy of the HIPAA notice of Privacy Practices:

____________________________________ ____

Signature of patient, parent or guardian Date

Treatment Consent:

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all mutually agreed upon treatment and employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand the using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

____ ____________________________

Signature of patient, parent or guardian Date

____ ____________________________

Doctor Signature Date

Dr. Jonathan Vongschanphen, DDS, LVIF
2295 Fieldstone Drive, Suite 230, Lincoln, CA 95648 Office: 916-435-2800 Fax: 916-435-2801
www.drjondds.com

Getting to know you...

Jon Vongschanphen, D.D.S.

Patient Name ______________________________ Date_______________

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive care to enhance your smile, improve and maintain your dental function, and help you to prevent future dental problems."

To help us serve your dental needs best, we would like to know more about you.

Please take a moment to complete the following questions:

What do you expect from your visit with us today?

____

What is most important to you about your dental health?

____

In your opinion, what is the present condition of your mouth?

____

What would you like your teeth to be like in 10 or 20 years?

____

Are you aware there are medical conditions related to dental disease?

____

What do you know about Periodontal Disease?

____

If you could "enhance" anything about your smile what would it be?

____

What foods do you enjoy yet do not eat due to discomfort with your teeth or any area of your mouth?

____

What has been your overall experience in other dental offices?

____

Has "fear" or "cost" ever prevented you from getting the dental treatment you need or want? Y__N__

Please explain: ____

____

What "quality" of dentistry do you want us to focus on at this time? Please circle:

A) Patch It   B) Only treatment covered by insurance   C) Ideal / Best

Should you be in need of treatment at what point do you plan to "get started"? Please circle:

A) When it hurts   B) When it breaks   C) When it is recommended in order to prevent further deterioration

Please feel free to let us know more about how we can help make this your best dental experience.

____

____

Internal Office Use:

Dental Management Solutions, Inc. ©