



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:** _____

I agree to 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 | Y | N | Y | N | Y | N |
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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. You may be charged up to \$125 for any appointments that are missed or canceled 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 acknowledge to their content.

Signature of patient, parent or guardian

Date

Relationship to Patient

I have been given online access to the Dental Board of California's Dental Materials Fact Sheet:

Signature of patient, parent or guardian

Date

I have been given online access to 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

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 check one:

- 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 check one:

- 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: