



Patient Information

Patient First Name _____ Last Name _____ Middle Initial _____
 Address _____
 City _____ State WA ZipCode _____
 Cell Phone # _____ Home Phone # _____ Emergency # _____
 Date of Birth _____ Social Security # _____ Marital Status S / M / D / W
 Email Address _____ Height _____ Weight _____ Sex M / F
 Employer (if applicable) _____ Student Y / N
 Pharmacy Name _____ City _____ Zip Code _____

Responsible Party: (Check here if same as patient above) _____ Or, please fill in information below:

Name _____ Address _____
 City _____ State _____ Zip Code _____ Phone # _____
 Date of Birth _____ Social Security # _____
 Employer _____ Employer Phone # _____

Primary Insurance Information:

Name of Subscriber _____ Date of Birth _____ Sex M / F
 Address _____ Phone # _____
 Name of Employer _____ Group # _____
 Name of Insurance Company _____ Phone # _____
 Subscriber ID # _____ Social Security # _____
 Relationship to Patient : Self ___ Spouse ___ Child ___ Other ___

Secondary Insurance Information:

Name of Subscriber _____ Date of Birth _____ Sex M / F
 Address _____ Phone # _____
 Name of Employer _____ Group # _____
 Name of Insurance Company _____ Phone # _____
 Subscriber ID # _____ Social Security # _____
 Relationship to Patient : Self ___ Spouse ___ Child ___ Other ___

How did you hear about Aden Dental Family ___ Referral ___ Internet ___ Other _____
 Referred by another office Yes ___ No ___ If yes, which office _____

*** Please provide our office with your picture ID and Insurance card ***

ADEN DENTAL

Welcome to the practice of Dr. Thi Nguyen. It is our desire to provide you with the highest quality dental care in a pleasant and relaxing atmosphere. We will provide a thorough explanation of recommended treatment. It is our experience that patients want to know exactly why dental treatment is necessary prior to treatment. We believe that service to our patients is best when there is mutual cooperation and understanding.

DENTAL INSURANCE

We honor most dental insurances. However, several insurance plans require treatment to be performed only by a member dentist. If this applies to your dental coverage, you should receive a list of member dentists from your insurance company. Any questions concerning coverage may be discussed with our financial coordinator.

As a courtesy to our patients, we will obtain benefit information, attempt to verify eligibility and submit insurance claims. No guarantee is made for any estimated insurance benefits and the patient is financially fully responsible should insurance benefits be less than anticipated. Dental coverage is an agreement that the patient/policy holder has made with the insurance company, mostly through an employer. Your insurance company is responsible to you. We will notify you of any balances not paid by your insurance company. Sixty days following patient notification, any unpaid balance will begin to incur interest charges at the rate of 1.5% per month (18% annually) with a \$3.00 minimum service charge. Any returned checks will incur a \$25.00 charge.

Signing below authorizes payment directly to Aden Dental for dental benefits, otherwise made payable to you by your insurance company. If there are any questions regarding this, please do not hesitate to ask.

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Signing below authorizes Dr. Thi Nguyen to release any information regarding diagnosis and records of treatment rendered to you or your dependent to third party payers (your insurance company) and/or health practitioners (i.e. specialists for referrals).

PAYMENT OPTIONS

1. We ask that you cover your portion of fees **at the time you receive treatment**. You may pay by cash, credit or debit card.
2. Monthly payment plans are also available through Care Credit.

****WE WOULD ALSO LIKE YOU TO KNOW****

We appreciate a minimum of 48 business hours notice if you cannot make your reserved appointment time. ****We reserve the right to charge a \$75.00 per scheduled hour for failed appointments or cancellations with less than 48 hours notice.**** Thank you!

Patient Signature _____ Date _____

My Documents/Chart/Office Policy

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

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

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

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

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

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

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

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:

X

Date: _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting an Aden Dental staff member.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used, disclosed, and how you can access your information.

By my signing below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date Time

Printed name (*if signed on behalf of the patient*) Relationship
(Parent, legal guardian, etc.)

I _____ give Aden Dental my permission to speak
with _____ regarding my treatment/upcoming
appointments.

I _____ give Aden Dental my permission to leave
messages regarding upcoming appointments and treatment on **my home phone**
my cell phone my work phone my email address.

This form will be retained in your dental record

Last Update: ___/___/___ Initials: _____