Queanh Phan, D.M.D

Deelighted Smiles

5608 PGA Blvd #108 Palm Beach Gardens Fl, 33418 (561) 694-2900 Mail@deelightedsmiles.com

1 PATIENT INFORMATION

Date _____

Last Name _____

First Name _____ M initial _____

Address _____

City _____ State _____ Zip _____

Phone (cell) _____

Phone (home) _____

Email _____

Sex: Male Female Age: _____

Birthdate _____
Patient SS# _____

If child provide Parent Name: _____

If student, are you: Full time or Part time
School: _____

Referral by _____

2 DENTAL INSURANCE / EMPLOYMENT

Subscriber's name _____

Relationship to patient _____

Birthdate _____ SS# _____

Address _____

City _____ State _____ Zip _____

Insurance _____

Group # _____ ID# _____

Phone _____ Fax _____

Secondary insurance _____
Group # _____ ID # _____
Phone _____ Fax _____

Employer _____
Occupation _____

Work Phone _____
Address _____
City _____ State _____ Zip _____

3 EMERGENCY CONTACT

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Permission for the following person to have access to my personal and dental information:

Name _____ Relationship _____ Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

Address _____

City/State _____

Phone _____

Date of last visit _____

Important concerns regarding my dental treatment are: _____

_____

Do you require pre-medication? _____
If yes, what medication?

_____

How many times a day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Do you smoke or use tobacco?
If Yes/ how used? _____

How often? _____

for How long? _____ years.

Please indicate with a check for the following problems:

- ☐ Are you in pain? _____
- ☐ Discomfort, clicking or popping in jaw
- ☐ Red, swollen or bleeding gums
- ☐ Sensitive tooth, Sensitive gums
- ☐ Blisters/ sore in or around the mouth
- ☐ Ill fitting partial or full denture
- ☐ Lost/ Broken fillings
- ☐ Teeth Grinding
- ☐ Ringing in ears
- ☐ Broken/ Chipped tooth or bridge
- ☐ Stained teeth
- ☐ Lock Jaw
- ☐ Bad breath

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5 HEALTH HISTORY

Physician's Name _____ Phone _____ Date of last visit: _____

Have you ever used a bisphosphonate medication? Common brands are Fosamax, Actonel, Atelvia, Boniva: __Yes __No

Please indicate with a check any of the following conditions:

- ☐ AIDS/ HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

Women:

Are you pregnant ___Yes ___ No Due Date _____ Are you nursing? ___ Yes ___ No

Taking birth control pills? ___Yes ___No

6 MEDICATIONS

List any medications you are currently taking and reason:

_____

_____

_____

_____

_____

Pharmacy: _____

Phone: _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

_____

7 PATIENT CONSENT

By signing this form I understand and agree to the following office polices of QUEANH PHAN, DMD, II, PLLC
We require payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If account is not paid within 90 days of the date of service, the patient is responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.

I have completed this form truthfully, and understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care, to third party payers/ health practioners. I understand that my dental insurance carrier may pay less than the actual bill for my services,. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date _____

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8 ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health insurance Portability & Accountability Act of 1998 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed 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 Practice. 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.

- ☐ I give permission for all communications and appointment confirmation to be used by Queanh Phan DMD II PLLC
- ☐ Cell Phone ☐ Work Phone
- ☐ Home Phone ☐ Text Message
- ☐ Email
- ☐ I am granting permission for Queanh Phan DMD II PLLC to disclose their identity to anyone who may answer my phone
- ☐ As a new patient I am granting permission to obtain full mouth series X-rays and mandatory record photos that are only for dental records and are not shared unless granted permission by patient
- ☐ I am aware that a non-refundable deposit may be required to secure scheduled appointment times.

Signature: _____ Date _____

Relationship to Patient: _____ Name _____ Date _____

9 FINANCIAL GUIDELINES

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

-**No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level: in which case, you would be responsible for the difference.

- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of the service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered-** unless prior financial arrangements have been made.
- **Balance left over 90 days of the date of service will incur an 10% or $20 minimum monthly finance charge.** Patient is responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Last Minute Cancellation/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments and we appreciate the same courtesy from you.
- **Last minute cancellation or missed appointments** will be charged one dollar per minute for time allotted for your appointment with the doctors. $35 dollars fee for a missed hygiene appointment.

Signature: _____ Date _____