Sinchai
FAMILY DENTAL

MEDICAL HISTORY

Today's Date: _______________

LAST NAME ____________________________ FIRST NAME ___________________________ D.O.B. ______________

Are you under a physician's care? For what? ____
Family Physician: ________________________________ **Phone Number:** _____________________________
Preferred Pharmacy: _____________________________

Please check any of the following that apply:

- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Arthritis (any type)
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood thinners
- ☐ Blood Vessel Disease
- ☐ Bone disorders
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart defect
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes (any type)/cold sores
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Neck pains
- ☐ Nervousness/Depression
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Persistent Headaches
- ☐ Psychiatric Care
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: ____

For WOMEN Only:
Birth Control Pills: ☐ Yes ☐ No **Breast-feeding**: ☐ Yes ☐ No
Pregnant: ☐ Yes ☐ No ☐ 1-3 months ☐ 4-6 months ☐ 7-9 months

What current medications are you taking?

- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________

Have you ever taken Bisphosphonate drugs for osteoporosis treatment? ☐ Yes ☐ No
Do you have an ALLERGY to any of the following?

- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: ____________________________
  ____

(OVER PLEASE)

Sinchai FAMILY DENTAL

DENTAL HISTORY

Please check any of the following that apply:

- ☐ Sensitivity (hot, cold, sweets)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching of teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or taste in your mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Name of Previous Dentist:

____

Please share the following dates:

Your last cleaning: ___/___/____
Your last complete x-rays: ___/___/____
Your last oral cancer screening: ___/___/____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No
How much? How long?

____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

On a scale of 1-10, with 10 the highest rating (check 1):

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

____

Are you nervous about having dental work done?

☐ Yes ☐ No

Are you interested in sedation for dental work?
☐ Yes ☐ No
Do you consume grapefruit juice? ☐ Yes ☐ No
Do you consume herbal supplements? ☐ Yes ☐ No

Have you ever been required to take antibiotics before visiting the dentist? ☐ Yes ☐ No If yes, why____________
____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ Yes ☐ No

I have read the above medical and dental information, have reviewed it, and find it accurate. If there are any further changes in my clinical history, I understand that it is my responsibility to inform Dr. Sinchai. I also give permission for Dr. Sinchai to perform a clinical examination and to make recommendations for treatment.

I have chosen the dental provider: Sinchai Family Dentistry of my own free will.

X____________ (please initial)

PATIENT INFORMATION

Today's Date: _______________

LAST NAME _________________________________ FIRST NAME ___________________________________ M.I. ______
PREFERRED NAME ___________________________ D.O.B. ________________ SS# _______________________________
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Child ☐ Single Gender ☐ Male ☐ Female
ADDRESS ____
ADDRESS 2 ____
CITY ____________________________________ STATE ________ ZIP ______________
TELEPHONE (Home) _____________________ (Work) _____________________ (Cell) _____________________
EMAIL ____
PREFERRED CONTACT METHOD ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email
May we contact you via email and/or text messaging with reminders/confirmations of appointment dates and times? ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR OFFICE?
☐ Mail ☐ Internet ☐ Existing Patient Patient's name_________________________ ☐ Other_________________

PARENT/GUARDIAN INFORMATION (Person Responsible for Account if Patient is a Minor)

PARENT/GUARDIAN NAME ____
ADDRESS ____
ADDRESS 2 ____
CITY ____________________________________ STATE ________ ZIP ______________
TELEPHONE (Home) _____________________ (Work) _____________________ (Cell) _____________________

EMERGENCY CONTACT

NAME _________________________________ RELATIONSHIP _________________ CONTACT# __________________
NAME _________________________________ RELATIONSHIP _________________ CONTACT# __________________

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION (If Applicable – Please Enter NA In All Fields If Not Applicable)

PATIENTS RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child
SUBSCRIBER'S FULL NAME ____ SUBSCRIBER DOB ___________
INSURANCE COMPANY ____ PHONE ____________________
SUBSCRIBER SS# _______________________ SUBSCRIBER ID# ________________________________
EMPLOYER ____

SECONDARY INSURANCE INFORMATION (If Applicable)

PATIENTS RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child
SUBSCRIBER'S FULL NAME ____ SUBSCRIBER DOB ___________
INSURNACE COMPANY ____ PHONE ____________________
SUBSCRIBER SS# _______________________ SUBSCRIBER ID# ________________________________
EMPLOYER ____

LAST NAME _________________________________ FIRST NAME _____________________________ D.O.B. _______________

DATE _______________

NOTICE OF PRIVACY POLICIES

I have been provided access to Sinchai Dental's Notice of Privacy Practices (available online or in the office) and have had full opportunity to read and consider its term. I understand that the Notice of Privacy Practices governs how Sinchai Dental may use and disclose my health information and how I can get access to my health information.

ALL PATIENTS: Please list any family members with whom we may share your information (if applicable).
PARENT OR GUARDIAN INFORMATION SHOULD BE ENTERED IF PATIENT IS UNDER 18.

NAME ________________________________ RELATIONSHIP ____________________________ CONTACT# _________________________

NAME ________________________________ RELATIONSHIP ____________________________ CONTACT# _________________________

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Sinchai Dental to upload and store confidential patient information (including account information, appointment information, and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site may require a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality.

I also understand that State and Federal Laws, as well as ethical and licensure requirements, impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Sinchai Dental will represent and warrant that they will, at all times during the terms of this gathering and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Sinchai Dental has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORRED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

CUSTODY ISSUES

The following is Sinchai Dental's policy regarding potential custody issues that may arise. Both parents/guardians involved are required to resolve payment and appointment scheduling issues without involving Sinchai Dental. Our practice will not be responsible for resolving these issues for you. Sinchai Dental will not communicate directly with your attorneys unless required by a judge to do so. You are required to provide all legal documentation concerning the custody rights of your child/children. Sinchai Dental will not divide statements; however, separate payments will be accepted. The parent/guardian that brings the child to the dental visit will be responsible for paying all fees incurred on the date of service. If there are unpaid balances, that parent will be held responsible for all balances and late fees incurred and will be subject to collections proceedings. If you cannot appropriately resolve your custody issues, your child will be withdrawn from the care of Sinchai Dental.

(OVER PLEASE)

CONSENT FOR SERVICES AND FINANCIAL POLICY

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs or other diagnostic aids deemed appropriate. I authorize Sinchai Dental to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners via paper or electronic transmission.

Full payment is required at the time of service from all patients who do not have insurance coverage.

Sinchai Dental will file dental insurance as a courtesy for patients with active dental insurance. In order to provide this service, I will provide updated insurance information before each appointment. My unpaid deductible and any estimated patient portion of fees not covered by my insurance are due at the time of service. I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Sinchai Dental.

Every insurance company has a different policy regarding the extent of coverage for a given dental procedure. Sinchai Dental will do its best to estimate my patient portion and maximize my insurance reimbursement, but I understand these estimations **CANNOT BE GUARANTEED**. My insurance is an agreement between myself and my insurance company, and I am ultimately responsible for all charges. **If insurance DOES NOT PAY within 60 days of treatment, I understand that I AM RESPONSIBLE for full payment of the balance at that time.** Sinchai Dental accepts Visa, MasterCard, American Express, Discover, personal checks, or cash. Treatment can also be paid through Care Credit or other available third-party finance companies.

STEP ONE	Your *estimated* financial responsibility is due before treatment is rendered.
STEP TWO	The insurance company processes the claim and issues payment (if applicable).
STEP THREE	Your payment of the final balance is due. We will notify you after insurance processes the claim.

Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency. A service charge of 1.5% 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 agree to reimburse Sinchai Dental the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fee, incurred in such collection efforts. I acknowledge any demographic information provided by me, including my cellular phone number, may be used to contact me for any purpose, including collection efforts.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of 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 to discuss this statement, my account or my treatment.

X____

Patient or Parent/Guardian Signature