EASTPORT DENTAL

Dr. Vinh Huynh D.M.D

Date_____

ACCOUNT INFORMATION

Patient Name (Last, First) _____DOB_____/_____/_____

Address_____Apt/Suit/Unit_____

City_____ State_____ Zip code_____

Home phone_____ Cell phone_____ Email_____

Gender: M F Marital Status: S M W D College Student: Y N SSN_____-_____-_____

Emergency Contact_____ Emergency contact cell phone_____

Relationship to patient_____

Name of General Physician_____ Phone Number_____

Preferred pharmacy_____ Phone number_____

Parent or Guardian Name if patient is a minor_____

Relationship to patient_____ Phone Number_____

How did you hear about our office: Google Yelp Other_____

INSURANCE INFORMATION

Insurance Name_____ Insurance Phone Number_____

Policy Holder Name (last, first) _____ DOB____/____/_____

Relationship to patient_____

ID #_____ Group #_____

Employer Name_____

I verify that all my information is correct and up to date as of today. Any changes made I will notify EASTPORT DENTAL.

Patient/ Guardian Signature _____ Date_____

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Medical History

Do you have any of the following- Circle Yes or No

	YES	NO		YES	NO		YES	NO
Any heart Problems	☐	☐	Malignancies	☐	☐	Ulcer	☐	☐
Kidney problems	☐	☐	Diabetes	☐	☐	Anemia	☐	☐
Hepatitis/Type_____	☐	☐	Tuberculosis	☐	☐	Psychiatric care	☐	☐
AIDS/HIV	☐	☐	Sinus Problems	☐	☐	Radiation Treatment	☐	☐
Seizure/Fainting	☐	☐	Circulatory	☐	☐	Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐
Stroke	☐	☐	Low Blood Pressure Cold	☐	☐	Tobacco	☐	☐
Excessive Bleeding	☐	☐	Sores	☐	☐			

Allergic to any of the Following: (Circle all that apply)

Penicillin ☐ Sulfa Codeine ☐ Anesthetic ☐ Latex ☐ other_____

Yes No Any Complications associated with previous dental work or local anesthetic injections? If yes, please explain_____

Yes No Any changes in your health in the last year? If yes, please explain_____

_____

Yes No Currently under the care of a physician? If yes, please explain_____

_____

Yes No Any Surgeries Including Prosthetic implants? If yes, please explain_____

_____

Yes No Replacement Valves or Joints? If yes, please explain_____

_____

Yes No Mitral Valve Replacement? If yes, please explain_____

Yes No Premedicate with Antibiotics for dental treatment due to heart condition or joint Replacement. If yes, what do you take_____

Yes No Taking any prescriptions/Non-prescription Medications? If yes, please explain_____

_____

Yes No Currently taking Bisphosphonates? (ex. Fosamax, Boniva Actonel, Reclast Etc.) if so Name and Dosage_____

Yes No Women- Are you Pregnant/ Breast feeding?

Patient Name_____Date_____

Patient/Guardian Signature_____

Doctor Signature_____

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Appointment Policy

Minimum of 24HRS notice is required to change an appointment. Without notice you will be charged a cancelation fee of $35 per appointment. No show visits will be charged a fee of $35. As a courtesy appointments are confirmed via Text/ or Phone Call, All confirmed or Non-confirmed are the Responsibility of the patient. If patient shows up 10mins or more after appointment time this appointment may be rescheduled. Initials_____

We will not perform treatment on a minor if dropped off or left untended. A legal parent or guardian of a minor must remain in the office while treatment is being rendered. Initials_____

As a courtesy to all patients, we ask you to please turn off cell phones to void distractions during treatment. Initials_____

Only parents or guardians of a minor patient will be allowed in the treatment room during exams. Your presence will give is the opportunity to go over treatment and answer any questions you may have. Initials_____

Any request for dental records for personal use or other dental offices, Insurance companies, etc. can take up to 2 weeks. Initials_____

Financial policy

All copays including deductibles and out of pocket cost are due when services are rendered. Any changes to this policy must be prearranged before treatment. **Treatment plans are estimates only**, they are not a guarantee of payment from insurance once insurance pays any Remaining amount will be billed to patients. The Fees Incurred are the patient's responsibility, regardless of insurance coverage or implied benefits. Any payments not made in 30 days will be considered past due. If a special arrangement needs to be made please contact our office. Initials_____

We accept all payment options such as Visa, MasterCard, Discover, American Express, checks, cash, Care credit, Green sky loans. Initials_____

I have read and fully understand the above stated polices and agree to comply with these polices.

Patient or parent signature_____ Date_____

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Patient Responsibility Form

On your behalf, an insurance claim will be submitted to your insurance company, however we make no guarantee of payment on services rendered. **Even a written pre-estimate from your insurance company stating benefits is payable, does not guarantee an insurance payment will be received once treatment has been rendered.**

As always, fees incurred are patient's responsibility regardless of insurance coverage and implied benefits.

I have read and agree that I am responsible for any charges that are accrued for any rendered treatment, and that If I have insurance it does not guarantee that they will pay for treatment that was rendered.

Date_____

Patients Name_____

Patient Signature/Guardian_____

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Patient Acknowledgement Receipt of Privacy Notice

I,_____ herby affirm that I have received a copy of the *Notice of Privacy Practices,* also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice and does legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices*, whether I sign this Acknowledgement or not.

Date_____

Print name_____

Signature of patient/Guardian_____

Relationship with patient_____

FOR OFFICE USE ONLY

Received by:
Date received:
Patient Declined:
Staff signature: