Advanced Care Dentistry & Dentures

Vincent T. Vo, DDS ● Christine Hoang, DDS
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Name_____ Birth Date_____ Social Security#_____
Address_____ City _____ST_____Zip_____
Age_____ Sex: Female/ Male Cell Phone _____Home Phone_____
Work Phone_____ Email _____
Occupation_____Employer_____
We offer courtesy reminders via email & text, if you prefer to opt out of this service please select box □ Opt out
Marital Status: □ Married □ Single □Divorced □Widowed Student: ____Yes _____No School Name:_____
(College students only for insurance purposes)

Ethnic Origin Please Circle one of the following:
African Amer/Black Asian Bi-Racial/Multi-Racial Hispanic Native American White Other

How were you referred? (Please circle one): Friend (Name)_____ Flyer Google Bing
Business (Name)_____ Other(Please explain):_____

Emergency Contact: Name/Relationship_____Phone_____
Physician_____Address_____Phone_____
If minor, name of Parent/Guardian_____ Address (if different)_____
Dental Insurance_____I.D. #_____Phone_____
Policy Holder: _____ Policy Holders Date of birth:_____
Medical Insurance:_____Policy #_____Phone_____

Preferred Pharmacy Name:_____ Phone Number:_____

Circle any of the following which you have had or have at the present:

Heart Condition	Anemia or Hemophilia	Skin Rashes or Hives	Thyroid Disease (Hyper/Hypo)	Radiation Therapy(x-ray, Cobalt)
Heart Attack or Stroke (year_____)	Bruise Easily	Kidney Trouble	Cortisone Medicine	Chemotherapy (Cancer, Leukemia)
Heart Murmur	Shortness of Breath	Diabetes Type____ A1C___	Glaucoma	HIV Positive/AIDS
Chest Pains (Angina)	Swelling of Ankles	Sickle Cell Disease	Arthritis or Rheumatism	Venereal Disease
Heart Surgery (year_____)	Artificial Joint	Liver Disease	Pain in Jaw Joints	Genital Herpes
Artificial Heart Valve (year_____)	Lung Disease	Hepatitis A (infectious)	Fainting or Dizzy Spells	Cold Sores
Heart Pacemaker (year_____)	Emphysema	Hepatitis B (Serum)	Alcoholism	Epilepsy or Seizures
High Blood Pressure	Tuberculosis (T.B.)	Yellow Jaundice	Drug Addiction	Psychiatric Treatment
Rheumatic Fever	Asthma or Hay Fever	Blood Transfusion	Cancer or Tumor	Allergy to Latex

What is your present health? Good____ Fair____ Poor____
Do you have any disease, conditions or problems
not listed above?.....No Yes
If yes, please explain_____
_____
Are you presently taking any medicine or drugs? ……..No Yes
If yes, list drug, dosage and frequency (if you have a list please attach)
_____
_____
Are you allergic to any medicine, drug or other substance? No Yes
If yes, please list _____
_____
Are you now, or have you been under the care of a medical
doctor during the last two years?..... No Yes
Have you ever been hospitalized or had surgery?..... No Yes
If yes please describe _____
Have you ever had a reaction to a local anesthetic?..... . No Yes
Have you ever had a prolonged or unusual bleeding?.... No Yes
Have you ever had complications or illness following
Dental Treatment?..... No Yes
Have you ever had an injury or trauma to your face
or jaw?..... No Yes

Doctor Signature:_____

Are you having pain or discomfort at this time? No___ Yes___
Do you smoke or use smokeless tobacco? ……..... No Yes
Are you nervous or concerned about having dental
work done? ..... No Yes
Women: Are you pregnant now? No Yes Due Date: _____
Are you practicing birth control? No Yes
Do you anticipate becoming pregnant? No Yes
Have you had any complications or
Problems with previous pregnancy? No Yes

Dental treatment desired (circle):
Check-up Cleaning Cavities Missing Teeth Replaced
Cosmetic Bonding Teeth Extracted Complete Dentures
Orthodontics Partials Other_____
Do you have existing partial(s)/denture(s) No Yes
If yes, how old is your Denture(s)_____ Partial(s)_____

Last Check Dental Check & Cleaning:_____
Best time for dental Appointments are

Mon	Tues	Wed	Thurs	Fri	Sat	Anytime

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail.

Date_____ _____
Signature of Patient, Parent or Guardian

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Office Financial & Appointment Policy

Welcome to Advanced Care Dentistry & Dentures, where our mission is to enhance the lives of our patients through superior care and treatment that is consistent with our values and vision. We are dedicated to delivering comprehensive dental care of exceptional value that can dramatically improve not only our patients' smiles but also their health, happiness, and quality of life. We pride ourselves on our patient-centered practice, where we perform the highest level of care and service in a clean and well-organized environment.

All recommended treatments are in the best interest of our patients. We will not allow your dental insurance to dictate your treatment plan; therefore we will inform you before we perform any recommended treatment.

******NEW PATIENTS: CASH OR CREDIT/DEBIT CARDS ONLY******

DENTAL INSURANCE:

If you have dental insurance, please be aware that **IT IS AN ESTIMATE ONLY**. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage have additional limitations and exclusions. All estimated co-pays and deductibles are due at the time of service. ***X_____(Initial)***

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage and plan before your appointment. With this, we will estimate the insurance portion and your co-insurance. This may or may not be what the insurance company will actually pay. We'll do our best to help you receive maximum benefits. Patients are responsible for all balances incurred for services received. A late fee of 1.6% will be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. ***X_____(Initials)***

We will wait 45 days for insurance claims to be paid. After 45 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company. ***X_____(Initials)***

CANCELLATION/BROKEN APPOINTMENT POLICY

Dental treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment in the desired length of time. A broken appointment is a loss to three people --- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

I hereby agree to show up for my scheduled appointments on time and to give a 24 hour advance notice if I need to cancel or reschedule an appointment. $50 fee per hour may be assessed to your account NO SHOWS or SAME DAY BROKEN APPOINTMENTS. . ***X_____(Initials)*** for

Note: All cancellation fees must be paid prior to scheduling another appointment.

PREFERRED METHOD OF PAYMENT
All services must be paid at the time of service. For your convenience, we accept Cash, Bankcards and all Major Credit Cards – American Express, Discover, Visa, MasterCard, CareCredit and Checks(Checks must clear prior to completing treatment). There is a thirty five dollar ($35) returned check fee applied to your account in the event the bank denies your check for any reason. We also offer a revolving line of credit through a third party CareCredit(upon credit approval).

The parent or guardian that brings in a minor for treatment is the financially responsible party.

By signing below, I acknowledge that I have read, understood, and agree to the provisions of the above policy.

PATIENT'S NAME (PRINT):_____
PARENT/GUARDIAN NAME (PRINT):_____
PATIENT/GUARDIAN SIGNATURE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office Notice of Privacy Practices. (if its not attached you may request a copy of this)

Please Print Name_____

Signature_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because;

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)