Dr. Cindy Tseng D.D.S.
Dr. S. Jace Beattie D.D.S., M.S.D

General and Cosmetic Dentistry

PATIENT INFORMATION (Please Print)

Full Name _____ (Last / First / M.I.) Preferred Name _____

Home # _____ Work # _____ Cell # _____

Birthdate _____ Soc. Sec. # _____

Mailing Address _____ (Street / City / State / Zip)

Email Address _____

Employer _____ Referred By _____

RESPONSIBLE PARTY

Person Responsible for Account _____ (Last / First / M.I.)

Relationship to Patient _____

Home # _____ Work # _____ Cell # _____

Address _____ (Street / City / State / Zip)

Birthdate of Responsible Party _____ Soc. Sec. # _____

EMERGENCY CONTACT

Name _____ Phone _____

Address _____

Relationship to Patient _____

INSURANCE INFORMATION

	(Primary)	(Secondary)
Insurance Company	1. _____	2. _____
Name of Insured	1. _____	2. _____
Birthdate of Insured	1. _____	2. _____
Relationship to Patient	1. _____	2. _____
Social Security # of Insured	1. _____	2. _____
Employer	1. _____	2. _____
Policy or Group No.	1. _____	2. _____

DENTAL HISTORY

Previous Dentist _____ City _____

When was your last dental exam? _____

What is your immediate dental concern? _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Unhappy with appearance of your teeth	☐	☐	Burning sensation in your mouth	☐	☐
Unfavorable dental experiences/dental fears	☐	☐	Difficulty swallowing	☐	☐
Preference for no dental anesthetic	☐	☐	An unpleasant taste or odor in your mouth	☐	☐
Problems with effectiveness or had reactions to dental anesthetic	☐	☐	Jaw problems (temporomandibular joint)	☐	☐
Orthodontic treatment (braces) when _____	☐	☐	Difficulty opening your mouth widely	☐	☐
Periodontal (gum) treatment when _____	☐	☐	Stiff neck muscles	☐	☐
Bleeding gums	☐	☐	Awaken with an awareness of your teeth or jaws	☐	☐
Avoid brushing any part of your mouth	☐	☐	Tension headaches	☐	☐
Part of your mouth is sensitive to temperature	☐	☐	Clench or grind your teeth	☐	☐
Sore teeth	☐	☐	Jaw clicking or popping	☐	☐
			Lost any teeth	☐	☐

Are you allergic to any of the following? Aspirin ☐ Penicillin ☐ Erythromycin ☐ Codeine ☐ Latex ☐

Local Anesthetic ☐ Fluoride ☐ Metals (gold, stainless steel) ☐ Other ☐ _____

MEDICAL HISTORY

Physician Name _____ Phone _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Hospitalization for illness or injury	☐	☐	Head or neck injuries	☐	☐
Heart problems	☐	☐	Epilepsy, convulsions (seizures)	☐	☐
Heart murmur	☐	☐	Viral infections and cold sores	☐	☐
Rheumatic fever	☐	☐	Any lumps or swelling in the mouth	☐	☐
Scarlet fever	☐	☐	Hives, skin rash, hay fever	☐	☐
High blood pressure	☐	☐	Venereal disease	☐	☐
Low blood pressure	☐	☐	Hepatitis (type) _____	☐	☐
A stroke	☐	☐	AIDS / HIV Positive	☐	☐
Artificial prosthesis (i.e. heart valve or joints)	☐	☐	Tumor, abnormal growth	☐	☐
Anemia or other blood disorder	☐	☐	Radiation therapy	☐	☐
Prolonged bleeding	☐	☐	Chemotherapy	☐	☐
Emphysema	☐	☐	Emotional problems	☐	☐
Tuberculosis	☐	☐	Psychiatric treatment	☐	☐
Asthma	☐	☐	Antidepressant medication	☐	☐
Sinus problems	☐	☐	Alcohol / drug dependency	☐	☐
Diabetes	☐	☐	Presently treating for any illness _____	☐	☐
Kidney disease	☐	☐	Aware of a change in your general health	☐	☐
Liver disease	☐	☐	Often exhausted or fatigued	☐	☐
Jaundice	☐	☐	Subject to frequent headaches	☐	☐
Thyroid or parathyroid disease	☐	☐	Heavy smoker (1 pack or more per day)	☐	☐
Stomach or duodenal ulcer	☐	☐	Generally a nervous person	☐	☐
Arthritis	☐	☐	Often unhappy or depressed	☐	☐
Osteoporosis	☐	☐	FEMALE - Taking birth control pills	☐	☐
Glaucoma	☐	☐	FEMALE - Pregnant	☐	☐
Contact lenses	☐	☐	MALE - Prostate disorders	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications taken within the last two years _____

Please advise us in the future of any changes in your medical history or medications you may be taking. In the event suit is necessary to collect any outstanding monies for services rendered, patient, parent or guardian agrees to pay attorney fees, collection fees, and court costs.

_____

Patient's Signature Date

Dr. Cindy Tseng D.D.S.
Dr. S. Jace Beattie D.D.S., M.S.D.

General and Cosmetic Dentistry

We appreciate you choosing our practice for your dental care. In order for us to provide you with optimal service, we would like you to take a moment to read our office guidelines.

Payment is expected on the day of service. Our office does not bill patients. We will accept payment by cash, check, or credit card (Visa or MasterCard).

If you have insurance, we will bill the insurance company as a courtesy to you. However you are responsible for all changes incurred. We do collect your co-payment at time of service and any estimated portion. If your insurance company (primary or secondary) denies charges for any reason the financial responsibility is yours.

Minors (patients 17 years old and younger) must be accompanied by a parent or legal guardian. Unaccompanied minors will be denied treatment unless treatment and payment has been approved. Parents and legal guardians are not permitted in the operatories and are asked to wait in the reception area during treatment.

I understand that my appointment time has been especially reserved for me and that Dr. Cindy Tseng confirm appointments as a courtesy only. In the event I need to reschedule an appointment I understand that Dr. Cindy Tseng requires 48 hours working day notice. I understand if I am unable to give 48 hours working day notice I may be charged a fee of $45 per hour. We reserve the right to not reschedule an appointment or to cancel an appointment if we are unable to contact you. I understand that if I am more than 15 minutes late for an appointment, I will not be seen that day and will have to reschedule my appointment.

I authorize the dentist to preform diagnostic procedures and treatment for proper dental care. I authorize the release of any information concerning my (or my child's) dental health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I have read the office guidelines. I understand and agree to these guidelines.

Patient/Guardian Signature Date

Dr. Cindy Tseng D.D.S.
Dr. S. Jace Beattie D.D.S., M.S.D

General and Cosmetic Dentistry

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Dr. Cindy Tseng. The Statement of Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Dr. Cindy Tseng reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If Privacy Practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions became effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Patient Name: _____

Date: _____

Signature: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement: _____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

____ The patient refused to sign

____ Patient unable to sign

____ Communication barriers

____ Emergency situation

____ Other: Explain _____