



Dr. Cindy Tseng D.D.S.
General and Cosmetic Dentistry

PATIENT INFORMATION (Please Print)

Full Name _____ Preferred Name _____
Last First M.I.
 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	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Unfavorable dental experiences/dental fears	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Preference for no dental anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	An unpleasant taste or odor in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Problems with effectiveness or			Jaw problems (temporomandibular joint)	<input type="checkbox"/>	<input type="checkbox"/>
had reactions to dental anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening your mouth widely	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment (braces) when _____	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck muscles	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) treatment when _____	<input type="checkbox"/>	<input type="checkbox"/>	Awaken with an awareness of your teeth or jaws	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Tension headaches	<input type="checkbox"/>	<input type="checkbox"/>
Avoid brushing any part of your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Part of your mouth is sensitive to temperature	<input type="checkbox"/>	<input type="checkbox"/>	Jaw clicking or popping	<input type="checkbox"/>	<input type="checkbox"/>
Sore teeth	<input type="checkbox"/>	<input type="checkbox"/>	Lost any teeth	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type) _____	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Artificial prosthesis (i.e. heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol / drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Presently treating for any illness _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Aware of a change in your general health	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Heavy smoker (1 pack or more per day)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Generally a nervous person	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE - Taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE - Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	MALE - Prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>

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.
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 \$75 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.
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 _____