Dr's Signature

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name ______________________________________ Preferred name _______________ Birth date_________

If minor, parents names _______________________ Phone:_________________ Email:_______________________

Mailing address ___________________________________ City _________________State _______ Zip ____________

Employer _______________________________ Occupation ____

Emergency Contact Name __________________________________ # __________________________________

How would you like to be contacted: ❑CALL ❑TEXT ❑EMAIL ❑No Preference

Whom may we thank for referring you to our office?❑ Google ❑ Yelp ❑ Postcard ❑ Location

❑ Current Patient
Name:__________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security or ID number: ___________________________ Dental Insurance Co.___________________________

Covered by a spouse's/Parent's insurance? ❑ yes ❑ no Spouse's/Parent's Name______________________________

Spouse's/Parent's dental insurance company _______________________________ Group number ___________________

Spouse's/Parent's Birthday ___________________ Social Security or ID number __________________________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
NO YES (Please check any that apply)

❑ ❑ Cancer or tumor (please circle)
❑ ❑ Heart ailment or angina
❑ ❑ Heart murmur, mitral valve prolapse, heart defect
❑ ❑ Rheumatic fever or rheumatic heart disease
❑ ❑ Artificial joint or valve
❑ ❑ High or low blood pressure (please circle)
❑ ❑ Pacemaker
❑ ❑ Tuberculosis or other lung problems
❑ ❑ Kidney disease
❑ ❑ Hepatitis or other liver disease
❑ ❑ Alcoholism
❑ ❑ Blood transfusion
❑ ❑ Diabetes
❑ ❑ Neurologic condition
❑ ❑ Epilepsy, seizures, or fainting spells (please circle)
❑ ❑ Emotional condition
❑ ❑ Arthritis
❑ ❑ Herpes or cold sores
❑ ❑ AIDS or HIV positive
❑ ❑ Migraine headaches or frequent headaches
❑ ❑ Anemia or blood disorders
❑ ❑ Abnormal bleeding after extractions, surgery
❑ ❑ Hayfever or sinus trouble
❑ ❑ Allergies or hives
❑ ❑ Asthma

Do you smoke or use chewing tobacco? ❑ No ❑ Yes

Are you allergic to, or have you reacted adversely to any of the following?

NO YES
❑ ❑ Latex materials
❑ ❑ **Penicillin or other antibiotics (please circle)**
❑ ❑ Local anesthetics ("Novocain")
❑ ❑ Codeine or other narcotics
❑ ❑ Sulfa drugs
❑ ❑ Barbiturates, sedatives, or sleeping pills
❑ ❑ Aspirin
❑ ❑ Other:_______________________________

Are you taking any of the following?
NO YES
❑ ❑ Aspirin
❑ ❑ Anticoagulants (blood thinners)
❑ ❑ Antibiotics or sulfa drugs
❑ ❑ High blood pressure medicine
❑ ❑ Antidepressants or tranquilizers
❑ ❑ Insulin, Orinase, or other diabetes drug
❑ ❑ Nitroglycerin
❑ ❑ Cortisone or other steroids
❑ ❑ Osteoporosis (bone density) medicine
❑ ❑ Other: ______________________________
____

Women:
N ❑ Y ❑ May be pregnant/Trying to get pregnant
Expected delivery date: ______________
N ❑ Y ❑ Taking hormones or contraceptives

Are you in PAIN now??:____

Do you have any disease, condition, or problem not listed above?______________________________________

Please add anything else you would like us to know about:____

Signature of patient (or parent) ____________________________________ Date _______________

We at Novan Dental are dedicated to serving you in caring for your oral health. We take great pride and care in providing the best in dental care to you and your family. Therefore, we will be more than happy to assist you with any financial matter related to you dental needs.

Payment Options:
We ask for payment in full at each dental visit.
To accommodate you with this we accept the following methods of payment: Cash , Check, ATM/Check Card, Visa, MC, Amex, Disc, Care Credit, Spring Stone (with prior approval before your appointment)

Insurance/Finances :
We accept most insurance plans. Insurance plans are unique and adhere to specific covered and non-covered procedures depending upon your individual plan. We do our best to provide accurate treatment and insurance estimates with the information provided us and from our initial contact with your insurance company. For your convenience we will prepare Treatment Estimates in advance of dental services. Treatment is recommended regardless of insurance deductibles, maximums and plan limitations. In order to keep our fees to you as low as possible we ask that deductibles and co-payments be paid at the time of service. For your convenience an estimate for dental care will be prepared prior to scheduled appointments to help you avoid unexpected balances. Please be advised that you are responsible for all balances not paid by your insurance company. Your assistance may be necessary to receive payment from your insurance in a timely manner.

Delinquent Accounts:
Account balances are due upon receipt of practice statements. A Service Fee of $25 will be charged for Returned Checks or Unapproved Card Payments. Unpaid balances where no agreement has been made with our Billing Department to extend payment may be transferred to a Collection Agency without further notice.

Appointments:
Patient satisfaction and your time are very important to us. Every effort is made to stay on schedule so please arrive as scheduled. Advanced notice of 24-48 hours is requested to cancel appointments if necessary. Without sufficient notice, we do not have the opportunity to successfully fill your appointment therefore, that time remains open and it is too late to invite another patient for their care. A $45 fee may be charged for failed appointments when advanced notice has not been given.

I acknowledge that I have received and do understand Dr. Nguyen's Practice Policies

Patient Name	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have received a copy of Novan Dental's Notice of Privacy Practices (Notice) on this date indicated. If you have any questions regarding the information in Novan Dental's Notice of Privacy Practices, please do not hesitate to contact a staff member.

Patient Name (printed):____

Signature:____

If Patient Representative, Name (Printed):__________________Relationship to Patient:_____ ______-_________ ____

Date Notice Received:____________________

THE DENTAL BOARD OF CALIFORNIA DENTAL MATERIAL FACT SHEET

The following document is the Dental Board of California's Dental Materials Fact sheet.
The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact sheet, and its linkage to the DCA website does not constitute an endorsement to the content of this document.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE DENTAL MATERIAL FACT SHEET

Signature:____Date:_____________________

As required by chapter 801, statues of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be complete guide to dental materials science.

CONSENT FOR DENTAL TREAMENT

Consent for Dental Treatment I request and authorize Dr. Nguyen and his staff to provide me with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my dental health. At that time I request and authorize Dr. Nguyen and his staff to complete the accepted treatment for myself, (or my child).

Signature:____Date:_____________________