Advanced Care Dentistry & Dentures

Vincent T. Vo, DDS ● Christine Hoang, DDS
□ Pasadena - 5233 Fairmont Pkwy Ste F Pasadena, Texas 77505
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www.AdvancedCareDentistryandDentures.com

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

*It's never too late to smile!*

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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)

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _06_/_09_/_04, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations.
for example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your in capacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions for $15. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $0 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.)We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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