New Patient Information

Joe Liang, DDS, MS, FICOI
Fellow, the International Congress of Oral Implantologists
Phone: 9256860888, Email: drliangperfectsmile@yahoo.com
website: www.PleeasantHillDentalCare.com

Whom may we thank for referring you? ____

ABOUT YOU

Name: ____________________________ I prefer to be called_______________________________ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: ______________________________

Home Address: ____ City____________State____Zip________

Home Phone: (____) ______________ Work: (____) ______________ ext. ___ Pager: (____) ______________

Cell: (____) ________________ E-mail Address: ____

Employer: ____________________________ How long there? _______________ Occupation: _________________

Employer's Address: ________________________________ City_______________ State________ Zip__________

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: __________________________________ Birth date:___/___/___ Relation: ______________

Billing Address: ____ City____________State____Zip________

Home Phone: (____) ________________ Work: (____) ________________ S.S. #: ___________________________

Employer: __________________________________ How long there? _________ Occupation:___________________

SPOUSE INFORMATION

[ ] Same as above Name: ____ Birth date: ___/___/___

Employer: ____ Work Phone: (____) ___________ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: ____________________________ Phone: (____) ________ Group/Policy #: ________________

Insured's Name: _______________________________ Insured's Birth date: ___/___/___ Relation: ________________

Insured's Social Security #: _____________________________ Insured's Employer: ___________________________

Secondary Insurance

Insurance Co. Name: ____________________________ Phone: (____) ________ Group/Policy #: ________________

Insured's Name: _______________________________ Insured's Birth date: ___/___/___ Relation: ________________

Insured's Social Security #: _____________________________ Insured's Employer: ___________________________

MEDICAL HISTORY INFORMATION

Name of Physician: ____ Phone: (____) _________________________

Do you have or have ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Diabetes
[ ] Epilepsy or Seizures
[ ] Excessive Thirst
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disorder (Congenital)*
[ ] Heart Infection*
[ ] Heart Murmur*
[ ] Heart Pace Maker*
[ ] Heart Surgery*
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorders
[ ] Mitral Valve Prolapse*
[ ] Osteoporosis
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Stroke
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

YES NO

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: ____

[ ] [ ] Are you now under the care of a physician?
If yes, explain: ____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: ____

[ ] [ ] Are you taking any medications or herbals?
If yes, list: ____

[ ] [ ] Are you allergic to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _________________________

[ ] [ ] Have you used tobacco?
If yes, explain: ____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X ____ Date ________________________
Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ____________ and confirm that it states past and present conditions.

Date:	Exceptions:		Patient's Signature:
____________	______________________________________	[ ] None	X _________________________________
____________	______________________________________	[ ] None	X _________________________________
____________	______________________________________	[ ] None	X _________________________________

DENTAL HEALTH QUESTIONNAIRE

We are committed to your treatment being sucessful. By answering the following questions, we can better understand your dental health, your goal to achieve the dental treatment; it will help us to properly complete your examination, and set up the appropriate treatment plan to meet your needs.

Please help us better understand your dental health needs and goals by answering the following questions.
(check the best answer):

Reason for today's visit ____________________ Date of Last dental Visit ___________________________
Former Dentist _________________________ City/State ___________________________________

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable**.
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**.
6. I would say that my main concerns with my dental health are: ____
7. I am interested in improving my smile. [ ] Yes [ ] No
8. Do you smoke cigaretee, pipe, cigar or use any tobacco products? __ Yes ___ No
9. Do you have clikcing or popping jaw, or pain around ear? __ Yes __ No
10. Have you had periodontal treatment before? __ Yes __ No
11. How often do you floss? _____ How often do you brush? _____

12. Please check which statement below best represents the level of dental health you wish to achieve.
(Some people begin at one level and progress to a higher level over time.)

__ Emgergency Care Only
I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the treatment of rest of my dental problems at this time.

__ Maintenance Care
I believe my present state of dental health is good, therefore, I am interested in maintenance care only.

__ Comprehensive Care
I think I do have some dental problems/concerns (functional and cosmetic). I want all dental treatment to solve all the problems to improve both function and/or esthetics of my smile.

Appointments
As a courtesy, we give reminder calls the day before the appointment day. However, the patient is expected to come to their appointed time whether they are reminded or not. Unless cancelled at least 24 hours in advance, we reserve the right to charge a $30 broken appointment fee. We treat all of our patients in a professional way and expect our patients to treat us likewise. In case of a real emergency, we will waive the fee.

Payment and Charges: Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Balances in excess of 90 days are subject to a finance charge of 1.5% per month (18% annual). Returned checks are subject to a $15 accounting fee. If the account is turned over to collections, there will be an additional $30 added onto the balance for collection.

Payment Options:

You can choose from:
- Visa, Mastercard, American Express, or Cash, Check.

- We offer a 7% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $500 or more.

- NO INTEREST Payment Plans from CareCredit (Please consult our receptionist for detail information).
o Allow you to pay over time with NO INTEREST.
o Convenient, low monthly payment plans also available.
o No annual fees or pre-payment penalties.

- For patients have dental insurance, we will bill your insurnace company and allow you to pay only your estimated out of pocket co-payment at the time of service. Any portion unpaid by your insurance company after 60 days becomes your responsibility. Please be aware that some, and perhaps all of the services provided may not be covered under your insurance. If a procedure is not covered, you will be expected to pay for the full amount at the time of service, or arrange for an extended payment plan.

- Adult parents are responsible for payment for minor patients.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Liang. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Liang to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Liang.

Photography Release

I authorize Dr. Liang to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients.

X ____ Date ______________________
Signature of patient, parent or guardian