

**NEW PATIENT INFORMATION – ADULT**

**Patient's Name**(FIRST MI. LAST): \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Sex:  Male  Female  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN # \_\_\_\_\_ **Email Address:** \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_ Cell#:(\_\_\_\_) \_\_\_\_\_ TEXT OK?  Y  N  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Dept: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Do you have **dental insurance?**  Y  N Insurance Carrier Name: \_\_\_\_\_ Group/ID #: \_\_\_\_\_  
 Plan Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**MARITAL STATUS** or Person Responsible for account, if other than yourself

- SINGLE  MARRIED (PLEASE FILL OUT BELOW)  DIVORCED  WIDOWED

**Name** (FIRST MI LAST): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
IF DIFFERENT THAN ABOVE  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Telephone #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_ Cell#:(\_\_\_\_) \_\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Dept: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Are you covered by your spouse's dental insurance?  Y  N Ins. Carrier Name: \_\_\_\_\_ Group /ID #: \_\_\_\_\_  
 Plan Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY CONTACT** Please list the nearest relative/friend not living with you:

Name(s): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Home Telephone #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_ Cell#:(\_\_\_\_) \_\_\_\_\_

**HEALTH PROVIDERS**

Name of Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?**

- Yellow pages  Internet: (SITE) \_\_\_\_\_  Friend/Co-worker (NAME) \_\_\_\_\_  Other \_\_\_\_\_

**DENTAL HISTORY**

**What is the primary reason for your visit today?** \_\_\_\_\_  
 Date of last visit to the dentist: \_\_\_\_\_ Date of last x-rays \_\_\_\_\_ Date of last cleaning \_\_\_\_\_  
 Name of previous dentist: \_\_\_\_\_ Phone#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 What, if anything, has happened in previous experiences at the dentist that gave you reason not to return?  
 \_\_\_\_\_  
 Have you ever had any serious problem associated with previous dental treatment or any dental emergency?  Y  N  
 If yes, describe: \_\_\_\_\_  
 Are you apprehensive about dental treatment?  Y  N If yes, explain \_\_\_\_\_  
 What, if any, would prevent you from having dental treatment? (RANK IN ORDER #1 -4; #1 BEING THE PRIMARY REASON )  
 \_\_\_\_\_ Fear of Pain/Discomfort \_\_\_\_\_ Cost of Treatment \_\_\_\_\_ Lack of Concern \_\_\_\_\_ Missing Work Time

**DENTAL HEALTH:**

**How would you describe your dental health?**  Excellent  Good  Fair  Poor

**Do you have any of the following conditions?**

Sensitivity to hot or cold	<input type="checkbox"/> Y <input type="checkbox"/> N	Gums bleed frequently	<input type="checkbox"/> Y <input type="checkbox"/> N
Sensitivity to pressure/when biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaw clicks or pops or soreness	<input type="checkbox"/> Y <input type="checkbox"/> N
Avoid chewing on one side	<input type="checkbox"/> Y <input type="checkbox"/> N	Snoring	<input type="checkbox"/> Y <input type="checkbox"/> N
Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Missing/loose teeth	<input type="checkbox"/> Y <input type="checkbox"/> N
Clench or grind teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Blisters on lips or mouth	<input type="checkbox"/> Y <input type="checkbox"/> N
Dry mouth/excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Sores/Growth inside mouth	<input type="checkbox"/> Y <input type="checkbox"/> N
Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Gums swollen or tender	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Have you had any of the following treatments?**

Orthodontic treatment (braces)  Y  N  
 If yes, what age? \_\_\_\_\_  
 Periodontal (gum treatments)  Y  N  
 Wisdom Teeth extracted?  Y  N  
 Dental Implants  Y  N  
 Night guard (occlusal guard)  Y  N

PLEASE COMPLETE OTHER SIDE

**DENTAL HYGIENE**

Patient Name: \_\_\_\_\_

How many times a day do you brush your teeth?

- 0-1  2  3  4  5 or more

How often do you floss?

- never  rarely  at least 2x/wk  every day  more than 1x/day

Do you use an electric or motorized toothbrush?

- No  Yes (brand \_\_\_\_\_)

Are you interested in learning more about Sonicare's FlexCare + ?

- No  Yes

**DENTAL AESTHETICS**

How do you feel about the appearance of your teeth?  Great  Good  Okay  Not so good  Horrible

If you could change anything about your smile, what would you change?  healthier  whiter  straighter  other (specify below )

**PATIENT RESPONSIBILITIES**

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

**FINANCIAL RESPONSIBILITY**

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, check, and any major credit card. Third-party financing is also available through CareCredit (www.carecredit.com).

\_\_\_\_\_  
**INITIAL** I understand and acknowledge that I am financially responsible for the services provided for myself regardless of insurance coverage, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received within 60 days, I understand that a 1.5 % finance charge (18% APR) will be added to my account, including at \$5 late fee, in addition to any collection charges.

**DENTAL BENEFIT PLANS**

Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. We ask that you notify us with any changes to your employment or dental benefits.

\_\_\_\_\_  
**INITIAL** **Financial Responsibility & Assignment of Benefits:** I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist/practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize direct payment of the dental benefits otherwise payable to me, to Dr. Andrew W. Yap, DDS.

\_\_\_\_\_  
**INITIAL** **Release of Information:** To the extent permitted by law, I consent to the use and disclosure of my protected health information, including my signature and social security number, to carry out payment activities on all insurance submissions.

**PATIENT INFORMATION AND PATIENT RIGHTS**

\_\_\_\_\_  
**INITIAL** **Facts about Fillings:** I have been given the opportunity to read and ask questions about "The Facts About Fillings," a dental material fact sheet providing information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

\_\_\_\_\_  
**INITIAL** **Privacy Notification:** I acknowledge that I have been given the opportunity to read and ask questions about this practice's "Notice of Privacy Practices," which describes how my information may be used or disclosed.

\_\_\_\_\_  
**INITIAL** **Patient Records:** I understand that I have a right to request a copy of my dental records . I authorize the release of a portion or all of these records which are deemed useful for the diagnosis, treatment or consultation regarding my dental health, to other dental providers, dental specialists, and medical providers. I authorize the transmission of these records via e-mail and understand that there may be charges related to the duplication of xrays, should I request hardcopies.

**SCHEDULING and CONFIRMATION OF APPOINTMENTS BY PHONE, TEXT MESSAGES AND/OR EMAIL**

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$40 or deposit to reserve the appointment time again, may be required.

\_\_\_\_\_  
**INITIAL** I understand the scheduling policy and that I will be asked to confirm each and every appointment and can do so via phone, text or email.

**CONSENT FOR TREATMENT**

I authorize the dentist and his staff to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of my dental needs. I understand that some of these images may be used by dental insurance carriers to determine benefits and by dental laboratories for the fabrication of crowns, veneers, bridges, dentures or other appliances and that these images will become a part of my permanent dental record. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, office website, or advertisements for the purposes of advancing medical-dental education and/or promoting cosmetic dentistry. I do not expect compensation, financial or otherwise, for the use of these images.

I also authorize dentist to perform all recommended treatment mutually agreed by me and to use the appropriate procedures, medication, anesthetics and therapy indicated for such treatment. I understand that using anesthetic agents embodies certain risk.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my health and/or medication. Further, I will not hold the dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**If this consent is signed by a personal representative on behalf of the patient:**

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Reviewed by Dentist:

\_\_\_\_\_  
Date: \_\_\_\_\_