FAMILY TREE
DENTISTRY, P.A.
DOAN BUI, DDS

Patient Profile

Patient Name: **Today's Date:**_____/_____/_____

_____ _____ _____ _____
Last Name (Legal) First Name (Legal) MI Preferred Name

Title: Mr. / Ms. / Mrs. **Male / Female/ Other** **Family Status:** Married / Single / Child / Other

Birth Date: _____/_____/_____ Email: _____

SSN:_____/_____/_____ *(Not required for patients under 18)*

Phone: _____ _____ _____
Home Mobile Work

Address: _____ _____
Address 1 Apt.

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice?_____

Other family members seen by us: _____ _____

If there's a procedure our doctor does that we can maximize your insurance benefits we would like to have that information on hand. Please provide the front office with a copy of your dental and/or medical card. Thank you.

Dental Benefits

Insured's Name: _____Relation:_____Insured DOB:____/_____/_____

Subscriber Social Security Number (Required if you would like for us to submit claims on your behalf)

SSN:_____/_____/_____ Insured Employer_____Group#_____

Benefit Company Name:_____ID#_____

Claims Address: _____City:_____

State:_____Zip Code:_____Phone# _____

Medical Benefits

Insured's Name: _____Relation:_____Insured DOB:_____/_____/_____

SSN:_____/_____/_____ Insured Employer_____Group#_____

Benefit Company Name:_____ID#_____

Claims Address: _____City:_____

State:_____Zip Code:_____Phone# _____

Family Tree Dentistry, PA
Patient Registration Continued

Patient Name_____Birth Date: _____/_____/_____

I understand that the information I have given today is correct and to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

By signing below, you authorize your benefits company to pay the provider all benefits rendered, authorize the use of electronic signature on all claims submissions, authorize the provider to release all information necessary to secure the payment of benefits.

I understand I am responsible for payment of services prior or at the time they are rendered. If this office participates with my benefits plan, I understand I am also responsible to pay any copayment and deductible prior or at the time services are rendered.

_____	_____	_____
Patient Signature (or Guardian if patient is a minor)	Relation if other than patient	Date

Family Tree Dentistry, PA

Health Insurance Portability and Accountability Act

Patient Name_____Birth Date: _____/_____/_____

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. PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This Notice takes effect until we replace it. We reserve the right to change your privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. Once we make a significant change in our privacy practices, we will change this Notice and clearly post the new Notice at our practice location, and will provide copies of the new Notice upon request. You may request a copy of our Notice at any time.

Initials _____ I give Family Tree Dentistry consent to release private health information solely for the benefit of my continued quality healthcare. Healthcare information to be released to my primary care physician, specialist physicians directly involved in my care, referring doctors, insurance company, or other dental specialists involved in my dental care. For this purpose private health information is defined as personal information, an examination finding, financial estimates, and/or treatment either proposed, underway or completed.

Initials _____ I grant Family Tree Dentistry permission to leave reminders and/or pertinent messages at my contact phone number, text messages, answering machine/voicemail per my request, and /or email or letter.

Initials _____ I grant Family Tree Dentistry permission to disclose my personal health information to the following person(s):

Information to be disclosed (please check):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ Any other pertinent dental health information related to treatment at this office
- ☐ None of the above

Name:_____Relation:_____Phone#_____

Name:_____Relation:_____Phone#_____

Signature

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____	_____	_____
Patient Signature (or Guardian if patient is a minor)	Relation if other than patient	Date

Family Tree Dentistry, PA

Patient Health History

Patient Name_____Birth Date: _____/_____/_____

Your current physical health is: Good / Fair / Poor Physician (Medical Doctor) Name: _____

Please list any prescription, over-the-counter medicines, herbal or diet supplements currently being taken and for what conditions:

_____to treat _____, _____to treat _____,

_____to treat _____, _____to treat _____,

- Any history of taking bisphosphonates? ☐Yes ☐No
- Do you take antibiotic premedication for your dental visits? If yes, please explain. _____
- Pharmacy Name & Address: _____Pharmacy phone#_____

Have you ever had or are currently experiencing any of the following diseases or medical conditions? (check all that apply)

☐ADD/ADHD	☐Cancer	☐Hepatitis	☐Osteoporosis	☐Smoker/Tobacco Use
☐Abnormal Bleeding	☐Celiac Disease	☐High Blood Pressure	☐Pacemaker	☐Stroke
☐Acid Reflux/GERD	☐Circulatory Problems	☐Hypoglycemia	☐Parkinson's Disease	☐Thyroid
☐Alcohol Use	☐Crohn's Disease	☐High Cholesterol	☐Pregnancy (current)	☐Tourettes
☐Allergies	☐Deaf/Hard of Hearing	☐Jaw Pain	☐Psoriasis	☐Tuberculosis
☐Anemia	☐Dementia	☐Kidney Disease	☐Radiation Treatment	☐Tumors/Growth
☐Anxiety/Depression	☐Diabetes	☐Liver Disease	☐Respiratory Problems	☐Ulcerative Colitis
☐Arthritis	☐Dry Mouth/Xerostomia	☐Low Blood Pressure	☐Restless Legs	☐Ulcers/Stomach
☐Artificial Joints	☐Eczema	☐Lupus	☐Rheumatism	☐STD
☐Asthma	☐Emphysema	☐MVP	☐Seasonal Allergies	☐Sleep Apnea
☐Autism/Asperger's	☐Epilepsy	☐Mental Illness	☐Seizures	☐Jaundice
☐Autoimmune Disorders	☐Fainting/Dizziness	☐Migraines	☐Shortness of Breath	
☐Back Problems	☐Food Allergies	☐Myasthenia Gravis	☐Sinus Problems	
☐Bipolar Disorder	☐HIV/AIDS	☐Nerve Pain	☐Sjogren's Syndrome	
☐Blood Disorder	☐Glaucoma	☐Heart Disease/Prob	☐Nervous Disorders	
☐Blood Thinners	☐Heart Murmur	☐Neuropathy	☐Sleep Disorder	

- Female Patients: If you are currently pregnant: How far along are you?_____
- Recent hospitalization within the past year? If yes, please describe: _____
- Allergies: Are you allergic to any of the following? If so, indicate what kind of reaction you had:

  ☐Latex ☐Local Anesthetics_____

  ☐Medicines (Penicillin, Sulfa, etc)_____Other_____

  Do you have an epi pen ☐Yes☐No ☐Food_____
- If any conditions or alerts selected above need further clarification, please describe below: _____

  _____

I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Patient Signature (or Guardian if patient is a minor) Relation if other than patient Date

Family Tree Dentistry, PA

Office Policy - Payments and Appointments

Patient Name _____Birth Date: _____/_____/_____

Dear Patient,

Welcome to our office! Please take a moment to read our office policies. Understanding these policies will allow us to concentrate on your care.

Before starting dental treatment, we will explain your treatment and associated cost. We ask that a legal guardian accompany all minor children to appointments in our office in order to discuss diagnosis as well as authorize treatment. If a minor will be coming to appointments on their own, we will ask you to sign the treatment plan to document our office explaining the treatment/costs.

Our services are based on your health needs and not on your insurance coverage. If you have dental benefits, we will assist you in determining your estimated co-payment for each treatment. However, we do not provide a 100% guarantee of benefits payments. Each company is different, and the decision to pay is theirs. Please note that the contract of insurance is between you and your insurance company. We will do our best to provide you with accurate estimates. If for some reason your benefits do not pay, it is important to understand you will ultimately be responsible for the final balance.

We accept VISA, Mastercard, Discover, Apple Pay, CareCredit and cash payment. We do not take personal checks.

For treatment appointments over an hour long, a reservation fee is required when appointments are made. This fee will be considered prepayment towards your treatment unless an appointment is missed or proper notice is not given. Please understand that your appointment is very important to us. It is your responsibility to inform our office of any changes to your contact information. As a courtesy, we take extra steps to remind you so you don't forget. When an appointment is made, preparation, materials, and time is set aside for you. If you are unable to keep your scheduled time, please contact our office at least 48 hours in advance to change or cancel so that we may make that appointment available to other patients in need of care. An additional fee in the amount of $100 per hour scheduled treatment and $50 for scheduled preventive care will be added to your account if proper notice is not given. If you are more than 10 minutes late without prior notification to the office for a scheduled appointment, you will be listed as a no show and may need to reschedule your appointment. In the event of an emergency, please contact our office as soon as possible. More than three missed appointments could regrettably result in an inability to reschedule you in our office.

These office policies are designed to offer the best quality dental care to our patients. Please help us achieve our goal.

Sincerely,
Dr. Doan Bui and the Family Tree Dentistry Team

I have read and understand the above office policies.

_____	_____	_____
Patient Signature (or Guardian if patient is a minor)	Relation if other than patient	Date