Date: _____

Patient's Last Name_____ First Name _____ (MI)_____

Home Address_____
Street CITY STATE ZIP CODE

Patient's SS#_____-_____-_____

Birth date _____Age_____

Preferred name (**nickname**)_____

Home Phone_____Cell_____

Drivers License #_____

Email Address_____

Occupation_____

Employer_____

Work Address_____

_____

Work Phone_____

Spouse's name_____

DENTAL INSURANCE

Do you have dental insurance? Yes? No?
If yes, please provide us with the following information:

Insurance Co.
#1_____

Group#_____

Do you have other dental insurance coverage? Yes? No?
Other Insurance Co.
#2_____

Group#_____

Insured's Name_____

Insured's Date of Birth _____

Insured's Person's SS# _____--_____--_____

Insured's Occupation_____

Insured's Employer_____

Address_____

_____

Phone Number _____

This coverage is through Self? Spouse? Parent? Other?

Were you referred to our office? If yes, by who?

_____

Patients' regular physicians:

_____

Date of last physical examination?

_____

Your current health is? Good? Fair? Poor?

Do you smoke or use tobacco? Yes? No?

Are you presently taking any prescription drugs? Yes? No?
If yes, please list:_____

_____

_____

Do you HAVE/HAD any of the following Medical problems?

Y N	Heart Attack/Stroke	Y N	Hepatitis A, B, C
Y N	HIV +/Aids	Y N	Cancer/Chemotherapy
Y N	Shingles	Y N	Heart Surgery/Pacemaker
Y N	Kidney Problems	Y N	Anemia
Y N	Sinus Problems	Y N	(High) (Low) Blood Pressure
Y N	Heart Murmer	Y N	Severe Headaches
Y N	Diabetes	Y N	Psychiatric Problems/Anxiety
Y N	Drug/Alcohol Abuse	Y N	Tuberculosis (TB)
Y N	Respiratory Problems	Y N	Sickle Cell Disease
Y N	Joint Replacement	Y N	Epilepsy/Seizures/Fainting
Y N	Hemophilia	Y N	Rheumatic Fever
Y N	Endocarditis	Y N	Mitral Valve Prolapse
Y N	Esophagitis/Reflux	Y N	Thyroid Problem
Y N	Artificial Heart Valve	Y N	Congenital Heart Defect

List any serious medical conditions not listed above?

_____

Have you ever been premedicated with antibiotics? Y N

Are you allergic to any of the following?

Y N	Penicillin	Y N	Dental Anesthetics
Y N	Erythromycin	Y N	Aspirin
Y N	Codeine	Y N	Latex

Are you allergic to any other drugs? If yes, please list:

_____

_____

For women, are currently pregnant? Yes? No?

Why have you come to the dentist today?

_____

_____

_____

Are you currently in pain? Yes? No?

Are you under stress or anxiety at home or work? Yes No

Do you experience stress in the dental office? Yes No

The approximate date of your last visit?_____

Have you ever experienced TMJ problems? Yes No
(TMJ is pain or discomfort in your jaw joints)

Your current dental health is? Good ? Fair? Poor?

Do you grind your teeth? Yes No

Do your gums ever bleed? Yes No

Would you like to improve your smile? Yes No

It is the patient/insured responsibility to notify office of any changes

CANCELLATION POLICY

We keep a cancellation waiting list for those of you who have last minute needs. If you need to cancel or reschedule you appointment, please do so 24 hours prior to your appointment time. If we do not receive this 24-hour notice, a charge may be assessed to your account.

LATE ARRIVALS

One of our office policies is to single book appointments and therefore we take pride in being on schedule as much as possible. With this in mind, we would appreciate you arriving on time for your appointment.

INSURANCE

I agree that it is my responsibility to understand my insurance benefits, deductibles, co-payments, and limitations. I further understand this office will bill my insurance as a courtesy to me, but I am responsible to pay any unpaid balances left by the insurance. I also understand that it is my responsibility to notify this office of any insurance changes. I understand the appropriate treatment will be provided for me, regardless of what my insurance policy and provisions are, and agree to pay any unpaid charges.

I understand my dental insurance carrier may reduce payment for Resin Restoration on posterior teeth and allow an alternate benefit payment of Amalgam restoration. I agree the difference between the dentist's charge for resin restoration and the amount paid by my insurance carrier is my responsibility. I agree to pay the difference after insurance for cosmetically enhanced procedures.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Simon Chun Tsang, DMD. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Simon Chun Tsang, DMD.. I understand that diagnosis or treatment of me by Dr. Tsang may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Simon Chun Tsang, DMD.. is not required to agree to the restrictions that I may request. However, if agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Tsang or Simon C. Tsang, PLLC office staff has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Patient Signature _____ **Date**_____

Guardian/parent signature _____ **Date**_____
(If a minor, parent or guardian)

Payment is due in full at the time of treatment unless prior arrangement has been approved.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: **By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

Notice of Privacy Practices: **You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.**

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: **AnnaLiza /O.M.** E-mail: smile@russelldentallv.com Telephone: **(702) 798-6216** Fax: **(702) 798-6269**

Right to Revoke: **You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

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 heath care operations.

Patient Signature _____ **Date**_____