Allie Tran, D.D.S., P.C. / Selina Tran, D.M.D., P.C. / Travis T. Le, D.D.S., P.C.
6134-M Arlington Blvd. Falls Church, VA 22044
Tel. (703) 237-4521 · Fax: (703) 237-4679
www.CompleteDentalVA.com

First Name: _____ M. _____ **Last Name:** _____

Address: _____ **City**_____ **State**_____ **Zip:** _____

Home Phone #: _____ **Cell:** _____

Gender (please circle): Male Female Other **Marital Status:** Married Single Other

Date of Birth: ____/____/_____ **Soc. Sec. #** _____ **(is required for insurance w/o alternate Id#)**

Email: _____ can we send you email reminders and notifications? yes no

Emergency Contact: _____ **Relation:** _____ **Phone #** _____

Would you like to receive text message reminders for future appointments? Yes No

How did you find out about our office? (if referred by a patient list their name) _____

Consent

The undersigned hereby authorizes doctor or staff to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that all responsibility for payment for dental services approved in this office for my dependents or myself is mine, due and payable at the time of services are rendered unless other arrangements have been made. I understand that if a bill is past due, collection charges may be incurred to my account. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form. I understand that there will be a **charge of $50 for missed appointments or cancellation without 24 hours notice** if the office deems necessary. I understand that claims are sent out as a service, but **if insurance does not pay what was thought, it is the patient's responsibility.** I authorize this office to obtain any medical information about my dependents or me. I understand that this information will be kept in absolute confidence. I hereby authorize payment of the dental benefits otherwise payable to me directly to Complete Dental (Allie & Selina Tran, PC) **I have been shown a copy of Complete Dental Notice of Privacy Practices and Understand I can request a copy. I give consent to use my disclosed my protected health information to carry out treatment, payment activities and health care operations.**

X_____

SIGNATURE OF PATIENT, PARENT or GUARDIAN **DATE**

TURN PAGE OVER ---->

HEALTH HISTORY

Name: _____ Date: _____

Date of last dental exam: _____ Medical Exam: _____
Have you been hospitalized in the last 5 years? YES - NO (if yes, why?): _____
Are you currently under any medical treatment? YES - NO (if yes, for what?): _____

(FOR THE FOLLOWING QUESTIONS CIRCLE: YES OR NO. YOUR ANSWER IS FOR OUR RECORDS ONLY AND WILL BE CONFIDENTIAL. PLEASE NOTE THAT DURING YOUR VISIT YOU MAY BE ASKED SOME QUESTIONS ABOUT YOUR ANSWERS. OUR TEAM MAY ASK YOU ADDITIONAL QUESTIONS CONCERNING YOUR HEALTH)

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CIRCLE YES OR NO FOR ALL THE FOLLOWING QUESTIONS:

Heart Murmur	YES	NO	Cancer - which type?	YES	NO
Heart problems (Heart Attack, Surgery)	YES	NO	Chemotherapy	YES	NO
Do you have a Pace maker	YES	NO	Latex Sensitivity	YES	NO
Diabetes	YES	NO	Psychosis	YES	NO
Hepatitis A, B, C	YES	NO	Bipolar	YES	NO
HIV Positive or AIDS	YES	NO	ADD/ADHD	YES	NO
Venereal Disease (Herpes, HPV)	YES	NO	Glaucoma	YES	NO
Asthma	YES	NO	High Cholesterol	YES	NO
Emphysema or other Respiratory Illness	YES	NO	Liver Disease	YES	NO
Alzheimer	YES	NO	Abnormal Bleeding	YES	NO
Dementia	YES	NO	Thyroid Problems	YES	NO
Kidney Disease	YES	NO	Joint Replacements (Hip, Knee, other)	YES	NO

HAS A DOCTOR EVER TOLD YOU TO TAKE AN ANTIBIOTIC PRIOR TO YOUR DENTAL VISITS: ___YES ___NO

HOW IS YOUR BLOOD PRESSURE? I HAVE HIGH BLOOD PRESSURE: ___ I HAVE NORMAL BLOOD PRESSURE: ____
DO YOU SMOKE CIGARRETES? YES___ NO ___ HOW MANY PER DAY? _____

DO YOU HAVE OR HAVE YOU EVER HAD AN ALLERGIC REACCION TO THE FOLLOWING:

***Local anesthetics ------YES -- NO**
***Codeine, valium or other sedatives---YES---NO**
*** Aspirin ----------YES----NO**
***Penicillin or other antibiotics----------YES --NO**
*** Allergy to any other medicines? _____**

Please list the name of all medications currently taking: _____

FOR WOMEN ONLY:
- Are you pregnant? YES____ NO___ (How many weeks?) _____ Due Date?: _____

-Are you currently planning on getting pregnant? YES___ NO___ Are you breastfeeding? YES___ NO___

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask me for my healthcare provider contact information, who may release such records to you. I will notify the dentist of any change in my health or medications.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date
_____	_____	_____
Doctor Name	Doctor Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have understood and received a copy of this office's Notice of Privacy Practices.

Print Name: _____Date_____

Signature: _____

I give my permission to the dental office to discuss my treatment and or billing information to the following:

I_____ Relationship to patient (check one): ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild ☐ Legal Guardian ☐ Attorney (or representative) of patient ☐ Other:

Name: _____

Name _____

I also give my permission to the dental office to text, email, or call me to confirm my appointments and talk to me.

Name_____Signiture_____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 prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

Complete DENTAL
Let Us Make Your Smile Complete Yet!
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CONSENT FOR PHOTOGRAPHS/VIDEO RECORDING

I hereby consent for the doctors and staff at Complete Dental to take **intraoral** photos of my teeth. I understand that the use of these photographs will be for my own educational purposes and they will be displayed in my personal dental chart only.

I also understand and I am aware that while I am in the office I will be part of the office video recording security system.

Patient Name: _____

_____ _____
Patient/Guardian Signature Date