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

==> *Patient Information*

First Name: ________________ **M.I.** ______ **Last Name**: ________________

Salutation (circle one): Mr. Mrs. Miss Ms Dr. **Nickname**: ________________

Address: ________________ APT/Suite: ________ **City** ________________, **State** ____________ **Zip**: ____________

Home Phone #: ________________ **Work** #: ________________ **Ext:** ________ **Cell:** ________________

Sex: Male Female **Marital Status**: Married Single Divorced Separated Widowed

Date of Birth: ________/________/________ **Age**: ________ **Soc. Sec.** # ________________ (required for insurance w/o alternate Id#)

Email: ________________ @Gmail.com / Yahoo.com / Hotmail/ other ____________

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

Employment Status: Full Time Part Time Retired **Student Status**: Full-Time Part- Time **Name of School**: ________________

Name and number of Preferred Pharmacy: ________________

Whom may we thank for referring you? ________________

What is the ideal time for appointments? AM PM **Would you like to be on our short notice list?** Yes No

Responsible Party/ Policy Holder (Responsible party is the individual responsible for the bill or Insured) ____________

***Name of Insured*/ Responsible Party:** ________________

Relationship to Patient: Self Spouse Child Other: ________________

Soc. Sec. # (If different from Patient): ________________ **Date of Birth** (If Different) ________________

Employer: ________________

Address: ________________

City, State, and Zip: ________________

Employer Phone # ________________

Do you have another Dental Insurance? Yes No

If yes Please provide receptionist with necessary information. Thank You

Insurance Company: ________________

Address: ________________

City, State, and Zip: ________________

Insurance Phone #: ________________

Insurance Group #: ________________

Insurance ID #: ________________

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 failed appointments or cancellation without 48 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 (Dr. Allie Tran, D.D.S., Dr. Trung Le, D.D.S., Dr. Selina Tran, D.M.D.) **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.**

Staff Member: ________________ **Date:** ____________

X

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

HEALTH HISTORY

Name____ **Date**_____________________

Date of last health care exam: ___________________________ **what was this exam for:** ______________________________

Have you been hospitalized in the last 5 years? (Please circle) NO YES if yes, reason: _____________________

Are you currently receiving care NO YES If yes, nature of care: _______________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____

For the following questions circle yes or no. Your answer is for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (metrical valve prolapsed)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow Healing Mouth Sores	No	Yes
Hepatitis, Any form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement (Hip, Knee, other)	No	Yes
HIV Positive or AIDS related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Thyroid Problems	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	ADD/ADHD	No	Yes

Other Health Problems not listed above:

Are you required to Pre-Medicate with antibiotics before dental treatment? No Yes
Women: Are you pregnant No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S/D

Are you allergic or have you had a reaction to:

- Local anesthetics……….…….………..No Yes
- Codeine, valium or other sedatives……….No Yes
- Penicillin or other antibiotics…………No Yes
- Aspirin…………..…………………….……No Yes
- Other……………………………….….No Yes

Are you a smoker? No Ye If so, how much do you smoke per day? ____________

Please list any medications you are currently taking:

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I answer all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

X__________________________ X___________________________________ ________________

Patient (print name) **Patient Signature** **Date**

X__________________________ X___________________________________ ________________

Doctor (print name) **Doctor Signature** **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Purpose: This Notice of Privacy Practices presents the information that the HIPAA Privacy Rules require us to give our patients regarding our privacy practices. We must provide this Notice to each patient no later than the date of our first service delivery to the patient, after April 14, 2003. We must also have the Notice available to the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service form us to be able to read the Notice. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices for time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name X____

Relationship to Patient X____

Signature X____

Date X____

Office Use Only

I have attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

Date	Authorized Personnel	Reason

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACYPRACTICES NOTICE

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CONSENT FOR PHOTOGRAPHS

I ________________________________ hereby consent to the participation in the taking of photographs by the doctors and staff at Complete Dental of myself and/or my family members. I understand that the use of these photographs will be for promotional and educational purposes only. These photographs will be displayed in the office, our social media pages and/or promotional items.

I ________________________________ understand that this is not mandatory and I can refuse to participate at any time.

☐ Display In Office (Computer Monitor/TV)

☐ Social Media (Facebook, Twitter, Website)

☐ Display to doctors and office staff only

Patient Name: ____

__________________________________ ________________
Patient/Guardian Signature Date