**Pre-Treatment Estimate**

We will give you an estimate of your treatment. **THIS IS ONLY AN ESTIMATE**. Once treatment is started, we may find some teeth with more destruction from decay than we could initially anticipate from x-rays and oral exams. Some teeth with deep decay may require root canals and crowns that cannot be foreseen.

Full payment is expected at each visit for treatment received. We also have a Payment Plan that is very popular with many of our patients. If you would like to inquire about our payment plan, please ask. Arrangements for payment must be completed BEFORE treatment is started. Our staff will file your insurance for reimbursement. If you have any questions regarding your coverage, please ask our office staff. **Any disputes concerning what your insurance pays will be between you and your insurance company.**

There is a $25 CHARGE FOR ALL BROKEN APPOINTMENTS, for each 30 minutes, (both for dental work and cleanings) unless we are notified at least **24 hours before** your appointment. You must pay this fee before you can schedule another appointment. On short notice, we are unable to fill your allotted time with another patient. We will try our best to remind you of your appointment at least one day before you are scheduled. To do this we need your updated work and home phone numbers and address. Sometimes, in spite of our best efforts, we will not be able to reach you. Ultimately, it is your responsibility to remember your correct appointment day and time.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You may refuse to sign this acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

If you have any further questions, please let us know. We will be happy to assist you in any way we can.

Joe Kim, D.D.S., N.T. Nguyen, D.D.S., & Staff

I have read and understand this information.

Please sign:_____ Date:_____

# WELCOME

## one ABOUT YOU

Today's Date: ____/____/____ File #: ____

**Patient Name:** ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

**Employer:** ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

## two INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

## three ACCOUNT INFO

**Person ultimately responsible for account**

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

**Payment method:** ❑ Cash [redacted]

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

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## DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ ( ____ ) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

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## MEDICAL HISTORY

**What medications are you taking?** ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

| | | | |
|---|---|---|---|
| **Y N** Heart Attack / Stroke | **Y N** Thyroid Problems | **Y N** Cancer/Tumors | **Y N** Cosmetic Surgery |
| **Y N** Heart Surg./Pacemaker | **Y N** Kidney Problems | **Y N** Shingles | **Y N** Xray or Cobalt Treatment |
| **Y N** Heart Murmur | **Y N** Liver Problems | **Y N** Hepatitis | **Y N** Chemotherapy |
| **Y N** Rheumatic Fever | **Y N** Respiratory Problems | **Y N** HIV+/AIDS/ARC | **Y N** Asthma |
| **Y N** Mitral Valve Prolapse | **Y N** Sinus Problems | **Y N** Arthritis/ Rheumatism | **Y N** Difficulty Breathing |
| **Y N** Artificial Valves | **Y N** Stomach Problems/Ulcers | **Y N** Artificial Bones/Joints | **Y N** Diabetes/Hypoglycemia |
| **Y N** Heart Disease | **Y N** Psychiatric Problems | **Y N** Emphysema | **Y N** Leukemia |
| **Y N** Congenital Heart Defect | **Y N** Venereal Disease | **Y N** Fainting/Seizures/Epilepsy | **Y N** Anemia |
| **Y N** Chest Pains | **Y N** Alcohol/Drug Abuse | **Y N** Severe/Frequent Headaches | **Y N** High/Low Blood Pressure |
| **Y N** Scarlet Fever | **Y N** Tuberculosis TB | **Y N** Frequent Neck Pain | **Y N** Bleeding Problems |
| **Y N** Nervousness | **Y N** Jaw Problems TMJ/TMD | **Y N** Back Problems | **Y N** Glaucoma |

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

**For women:** Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

**UPDATE**
(OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

# PREMIER DENTISTRY

Joe Y. Kim D.D.S & N.T. Nguyen D.D.S.
435 W. President George Bush Hwy
Richardson, TX 75080

***Payment Options***

To help keep cost of Dentistry down, and to continue to provide quality care to our valued patients, we now only accept payment in full, the day of treatment.

Please circle the option(s) most convenient for you to settle your account, in full today,

X Cash/Check/Debit (in full) the day of treatment

X Visa Acct #_____ Exp Date _____

X M/C Acct #_____ Exp Date _____

X Amx Acct #_____ Exp Date _____

X Discover Acct #_____ Exp Date _____

X In house credit plan (*please see receptionist for application form)*

I _____ hearby authorize the Dental offices of Dr. Joe Kim to process payment, from time to time, as the Dental office deems necessary, to settle my account, in full.

X_____ X_____

Patients Name Date