Welcome to Dali Dental!!!

Please take a few minutes to fill out the following forms so we can better help you!!!

Date: _____

Last Name: _____ First Name: _____ MI: ____ Preferred Name: _____

Social Security_____ Birth Date: ____/____/_____ Gender: M F

Driver License #: _____ Marital Status: Married Single Divorced Widowed

Phone (Home): _____ (Work): _____Ext_____ (Cell): _____

E-mail: _____ Best way to contact you: _____

Address: _____
(street) (city/state) (zip)

Employer: _____ Occupation: _____

Emergency Contact Name: _____

Emergency Phone #: _____ Relationship to you: _____

Closest Relative not living with you (Name): _____

Address: _____ Phone #: _____

To whom may we release/discuss your dental information (ex. treatment plan, treatment history, payments, etc.)?

Name: _____ Relationship: _____ Phone: _____

To whom may we thank for referring you to our office? _____

If patient is a child/minor:

Father's Last: _____ First: _____ MI: _____

Phone (Cell): _____ (Work): _____ E-mail: _____

Mother's Last: _____ First: _____ MI: _____

Phone (Cell): _____ (Work): _____ E-mail: _____

Dental Insurance Information

Insured's Name: _____ Is Insured a patient? Yes No

Insured's Social Security #: _____ Birth Date: _____

Insured's address: _____
(street) (city/state) (zip)

Insured's Employer Name: _____

Patient's relationship to Insured: Self Spouse Child Other _____

Insurance Company: _____ Insurance Phone #: _____

Subscriber ID: _____ Group #: _____

Dental History

Reason(s) for today's visit: _____

Former Dentist: _____ Date of Last Dental Visit: _____

Would you change anything about the appearance of your teeth? Yes No

If yes, please explain _____

Please check if experienced/have ANY of the following dental conditions:

Bad Breath	Yes	No	Clicking or popping jaw	Yes	No
Bleeding gums	Yes	No	Food caught between teeth	Yes	No
Broken Fillings	Yes	No	Periodontal treatment	Yes	No
Grinding teeth	Yes	No	Orthodontic treatment	Yes	No
Loose teeth	Yes	No	Sore or Growth in mouth	Yes	No
Cold sensitivity	Yes	No	Sensitivity to sweet	Yes	No
Heat sensitivity	Yes	No	Sensitivity to biting	Yes	No

Medical History

Patient's Name: _____ Birth Date: _____

Medical Doctor's Name: _____ Phone#: _____

Date of last Doctor's visit: _____ Reason: _____

Have the patient ever had ANY of following medical conditions?

AIDS or HIV+	Yes	No	Epilepsy or Seizures	Yes	No	Psychiatric treatment	Yes	No
Alcohol/Drug dependency	Yes	No	Excessive Bleeding	Yes	No	Radiation Treatment	Yes	No
Allergies	Yes	No	Fainting	Yes	No	Respiratory Problems	Yes	No
Codeine	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Latex	Yes	No	Growths (Tumors)	Yes	No	Rheumatism	Yes	No
Penicillin	Yes	No	Hay Fever	Yes	No	Sinus Problems	Yes	No
Other _____			Head Injuries	Yes	No	Stomach Problems	Yes	No
Anemia	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No
Arthritis/Gout	Yes	No	Heart Murmur	Yes	No	Thyroid	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis	Yes	No	Tobacco use		
Artificial Joints	Yes	No	High Blood Pressure	Yes	No	(smoke/smokeless)	Yes	No
Asthma	Yes	No	High Cholesterol	Yes	No	Tuberculosis	Yes	No
Blood Disease	Yes	No	Jaundice	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No	Venereal Disease	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Take Aspirin/Blood thinner	Yes	No
Diabetes	Yes	No	Mental Disorders	Yes	No	Taken Fen-Phen/Redux	Yes	No
Dizziness	Yes	No	Nervous Disorders	Yes	No			

Have you been hospitalized or admitted to emergency care within the last 2 years? Yes No

If yes, please explain: _____

_____

Are you under the care of a physician? Yes No

If yes, please explain: _____

_____

Are you currently taking any medications? Yes No

If yes, please list medication(s), dosage and reason: _____

_____

_____

Do you have any health problems that need further clarification or we have not covered that we may need to know? Yes No

If yes, please explain:

_____

_____

Women Only:

Currently pregnant? Yes No Due Date: _____

Currently on the pill? Yes No

Currently nursing? Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health and/or medications, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient or guardian

Dr. Pham's Signature: _____ Date: _____

Dali Dental Office Policies

Thank You for choosing Dali Dental, PA as your dental provider. Our primary goal is to deliver the best and most comprehensive dental care available.

- Your appointment is time exclusively reserved for you. If you are late for more than 10 minutes, please give us a call. We try to be flexible; however, if you are more than 15 minutes late, we reserve the right to re-schedule your appointment.
- Should you need to change/cancel your appointment, please give us at LEAST 24 hours notice so we can offer your time to other patients awaiting treatment. Without proper notice, our office reserves the right to charge a $50.00 broken appointment fee.
- Saturday and evening appointments are highly desirable. If you missed 2 or more appointments without notice, you'll no longer be eligible for future Saturday and evening appointments.

Financial Policies

- Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment, or on pre-op visits for sedation appointments. Payment is collected when you check-in for your appointment.
- For your convenience, we accept Cash, Check, Visa, MasterCard, American Express and Discover Card
- We also accept CareCredit-flexible monthly payment options (interest free options available)
- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. Your insurance policy is a contract between you, your employer, and your insurance company.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.
- Insurance payments are ordinarily received and processed within 30-45 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied by 60 days, you will be responsible for paying the full amount at that time.
- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- If an account has a balance of 90+ days, you will be responsible for collection and/or lawyer/court fees if your account is sent to collection.
- Returned checks are subject to $50 bank & accounting fee.
- We do not accept secondary insurance.

Authorization and Consent

- I authorize and request my insurance company to pay directly to Dr. Pham and/or Dali Dental, PA the insurance otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I authorize Dr. Pham/Dali Dental to the making of photographs, x-rays, and videotapes before, during, and after treatment, and to their use by the doctor in scientific papers, demonstrations and/or case presentations.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name: _____ Date: _____

Signature of Patient/Parent/Guardian: _____ Relationship to patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

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

Print Patient's Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____

For Office Use Only (Employee's Initials: _____)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Individual refused to sign
- o Other: _____

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.