15595 LOS GATOS BLVD STE A
LOS GATOS CA 95032

WELCOME TO OUR PRACTICE!

Date: ____________________

Last Name: _______________________________ First Name: __________________________ Middle Initial: ___

Preferred Name: ____________________________ Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.

Gender: ☐Male ☐Female Family Status: ☐Child ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed

Birth Date: ______________________ Social Security #: ____________________________

Home Address: ____

City: ______________________________________ State: _____ Zip Code: ________________

Home Phone: ___________________________ Work Phone: _______________________________

Mobile: ____________________________ Email Address: ____

*How did you hear about us? Who may we thank for referring you to our practice?

____

*Last Dental Visit: ___________________________

*Last Dental Office: ____

*Any Dental Concerns:____

____

____

Emergency Contact:

Name: ____ Relation: _____________________________

Phone: _______________________________

Primary Dental Insurance

Name of Primary Subscriber if not patient: ____

Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Subscriber Birth Date: _____________________ Subscriber SSN/ID: _______________________________

Employer Name: ____

Employer Address: ____

City: ____________________________________ State: _____ Zip Code: _____________________

Insurance Plan Name: ____

Is the patient a student? ☐ Full Time ☐Part Time School Name: ______________________________

Secondary Dental Insurance

Name of Primary Subscriber: ____

Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Subscriber Birth Date: _____________________ Subscriber SSN/ID: _______________________________

Employer Name: ____

Employer Address: ____

City: ____________________________________ State: _____ Zip Code: _____________________

Insurance Plan Name: ____

Please present your insurance card so we may make a copy for our records.

Insurance Authorization

☐ By checking this box I authorize: my insurance company to pay the dentist all insurance benefits rendered, the use of this electronic signature on all insurance submissions, and the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by the insurance company.

Medical History

Are you presently being treated for a medical condition? ☐Yes ☐No

Have you ever been hospitalized or had a major operation? ☐Yes ☐No

Have you ever needed antibiotic premedication prior to a dental visit? ☐Yes ☐No

If you answered yes to any of the above, please elaborate:

If you are taking any medications, please list or bring a copy for our records:

Do you have or have you ever had any of the following?

☐AIDS/HIV+	☐Anemia	☐Artificial Heart Valve	☐Artificial Joints
☐Asthma	☐Bleeding Disorder	☐Cancer	☐Cold Sores
☐Diabetes	☐Epilepsy or Seizures	☐Head/Neck Injury	☐Heart Attack/Failure
☐Heart Murmur	☐Heart Pacemaker	☐Heart Trouble/Disease	☐Hepatitis B
☐Hepatitis C	☐Herpes	☐High Blood Pressure	☐Hives or Rash
☐Hypoglycemia	☐Liver Disease	☐Low Blood Pressure	☐Mental Disorder
☐Nervousness	☐Pain in Jaw Joints	☐Pop/Click in Jaw Joints	☐Phen-Fen/similar Rx
☐Psychiatric Care	☐Renal Dialysis	☐Respiratory Problems	☐Rheumatism
☐Sinus Problems	☐Smoke/Tobacco Use	☐Stroke	☐Tuberculosis
☐Tumors or Growths	☐Unexplained Weight Loss	☐Venereal Disease	☐Yellow Jaundice

*Allergies: ☐Aspirin ☐Codeine ☐Penicillin ☐Other ___________________________________

*Women, are you: ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

If you are pregnant, congratulations! How far along are you? ________________________________

*If any conditions are not listed above or further clarification is needed, please explain.

To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my/the patient's health. It is my responsibility to inform the office of any changes in medical status.

Patient or Guardian Signature ____

Date ____

CONSENT FOR SERVICES & OFFICE POLICIES

Financial and Insurance Policies:
It is our objective to provide our patients with the best care and dental materials. In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of their visit.

We will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you. Please take the time to read and understand your insurance policy and benefits.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A billing charge of $2.50 per statement period, and a service charge of 1.5% (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. Any accounts past due over 60 days will be forwarded to a collection agency.

The fee estimate listed for dental care can only be extended for a period of sixty days from the date of patient examination.

Office Cancellation Policy:
We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 2 weekdays notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, a $25 cancellation fee.

Compliance Policy:
Patients who have not been seen at the office for over a year or who have any combination of three missed appointments and/or lack of response to correspondence from our office will be moved to the inactive patient list and may continue dental care at an office of his/her choosing. Inactive patients who later decide to be moved back to the active list may do so however we do limit the amount of active patients we will be treating and cannot guarantee that the active patient list will be open at that time. If our list is at capacity we will recommend continuing dental care at another office of the patient's choosing.

Communications:
I consent to receiving cell phone calls and email communications regarding treatment, insurance and my account. I understand I can withdraw at any time.

HIPAA Acknowledgement:
I understand that I may inspect or copy the protected health information described by this authorization. A copy of the notice of privacy practices has been made available to me.

Dental Materials Fact Sheet:
A copy of the dental materials fact sheet has been made available to me.

I understand the above information and agree with its contents. I hereby authorize the office of Dr. Sheryl Ng, D.D.S. Inc. to perform any necessary diagnostic examinations and x-ray procedures they deem necessary including photographs, and the administration of anesthetic or treatment as deemed necessary or advisable in the treatment of my dental condition.

Patient or Guardian Signature ____

Date ____