



Happy Teeth Dental Care
Registration Packet

Welcome to Happy Teeth Dental Care!

Thank you for choosing our office for your dental needs. We look forward to meeting and working with you! Happy Teeth Dental Care is a professional and comprehensive dental care practice focused on building a foundation of trust by treating our patients of all ages with the utmost care. Our commitment is to ensure that you and your family feel welcomed, informed, and comfortable. Our key philosophy is prevention, and our team works hard to provide state of the art treatment, while taking the time to educate our patients about preventive care.

This initial registration packet is for us to get to know you, to help address your concerns, and your needs, get you processed into our system, and then continue on with the dental treatment and services as needed. If you have any questions please feel free to ask our front desk staff.

We will be happy to help you!

Patient Information:

First Name: _____ Last Name: _____ Sex: Male Female
Birth Date: _____ Age: _____ Home Phone: _____ Cell/Work Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Email: _____ Reminders: Yes, Please Email Me Yes, Please Text Me

Responsible Party: Self Parent/Guardian

First Name: _____ Last Name: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance Policy:

Primary Insurance: _____ Policy ID # _____
Policy Holder's Name: _____ Policy Holder's Birth Date: _____
Patient's Relationship to Policy Holder: _____

Secondary Insurance Policy:

Secondary Insurance: _____ Policy ID # _____
Policy Holder's Name: _____ Policy Holder's Birth Date: _____
Patient's Relationship to Policy Holder: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices (“Acknowledgement”)

By signing below, I acknowledge that I have received a copy of Happy Teeth Dental Care’s HIPAA Notice of Privacy Practices.

Patient Name (Please Print) _____

Patient/Personal Representative Signature: _____ Date: _____

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

***Please Note: it is your right to refuse to sign this acknowledgement.**

Dental Office Use Only:

I tried to obtain written acknowledgement by the individual noted above of the receipt of our Notice of Privacy Practices, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement
- A communication barrier prevented us from obtaining acknowledgement
- The individual was unwilling to sign the acknowledgment
- Other: _____

Staff Member Signature: _____ Date: _____

Medical History

Patient Name: _____ Birth Date: _____

Are you under a physicians care now? Yes No

If yes, please explain: _____

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

If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No

If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes No If yes, please explain: _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex

Local Anesthetics Sulfa Drugs Other: _____

Are you on a special diet? Yes No

Pregnant? Yes No

Do you use tobacco? Yes No

Taking Oral Contraceptives? Yes No

Do you use controlled substances? Yes No

Nursing? Yes No

Do you have/ had, any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Easily winded | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives/Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Frequent Coughs | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumor/Growth |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sore/Fever Blister | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Other _____ |

Additional Comments/Illness not listed above: _____

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

Patient/Responsible Party Signature: _____ Date: _____

Informed Consent for Dental Treatment and Procedures

1. You; the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consent to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

X-rays: *Proposed treatment: taking of intraoral and extraoral radiographs. Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are necessary for proper diagnosis and evaluation purposes. Alternative treatment: none; limited visual examination. Consequences of not performing: missed diagnosis. Common risk: Radiation exposure to soft and hard tissue. Patient Initial _____*

Cleaning: *Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefit of treatment: healthy oral environment; also reduction/elimination of bleeding, odor, and periodontal disease. Alternative treatment: referrals for periodontal surgery according to the severity of condition. Consequences for not performing: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues; lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss. Common risk: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint. Patient Initial _____*

2. Drugs and Medication

I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initial _____**

3. Change of Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to dentist to make any/all changes and additions as necessary. **Patient Initial _____**

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initial _____**

Patient/Responsible Party Signature: _____ Date: _____

Financial Agreement

- 1. Payments:** Payment is due on day of service. Payment options are cash, debit card, or credit card (VISA, MasterCard, or Discover). For financing larger treatments, we also offer Care Credit.
- 2. Dental Insurance:** Insurance is a contract between you and your insurance. There is no direct relationship between Happy Teeth Dental Care, PC and your insurance company. Benefits are determined by the plan selected by you and/or your employer and we are not a party to this contract. The terms of your contract, methods of reimbursement, and determination of your benefits are defined by your insurance company and not Happy Teeth Dental Care, PC. We will file your dental insurance claims as a courtesy to you. We do not guarantee payments and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay your portion of the charges not covered by your insurance.
- 3. Deposits:** To book an appointment for major services that require two or more hours, 50% of the total cost of the proposed procedures must be collected. The remaining 50% is due on day of service.
- 4. Cancellation/Broken Appointment Fee:** 48 hour notice of cancellation is required for all major procedures (ie. CEREC, root canal, dentures). A \$75.00/hour broken appointment fee will be applied to your account. 24 hour notice of cancellation is required for all other procedures (ie. cleaning, filling, follow up). A \$50 broken appointment fee will be applied to the account. A new appointment cannot be made until all fees are covered.
- 5. Emergency/After Hours Appointment:** Patients who are seen for an emergency visit after our regular business hours, an "after hour" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.
- 6. Finance Charge:** A finance charge of \$5.00 will be added to your account for any balance that remains unpaid after 30 days after receipt of notice. This charge will be assessed monthly, until the remaining balance is paid in full.
- 7. Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges made to the account, finance charges (if applicable), and any payment or credit applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment. We cannot send statements to other persons.
- 8. Past Due Accounts:** If your account is past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay the collections costs which are incurred.
- 9. Divorce:** In case of divorce or separation, the parent/guardian bringing the patient to the office is financially responsible. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the parent/guardian.
- 10. Effective Date:** Once you sign this agreement, you agree to all terms and conditions herein and the agreement will be in full force and effect.

This agreement is between your treating dentist; Nguyen M. Tau or Nguyet M. Tau, and the patient/parent/debtor named on this form.

