LEGACY
DENTISTRY

Patient Information:

Patient's Name ____

Address ____

City ____________________ State ______ Zip ____________

Is this address the same for the entire family? ___Yes ___No

Primary Contact Number _____-_____-_________

Date of Birth____/____/____Sex: (M) or (F)   Married Single Divorced Widowed

Email address ____________ Best way to reach you (Call, text, or email?) ______

Preferred confirm method: Call, Text, or Email

Preferred recall method: Call, Text, or Email

Occupation _____________ How did you hear about us? ________________

Do any of your family members see us for dental care? If so, who? ____________

Dental insurance information:

Subscriber ____

Subscriber ID ____

Subscriber DOB ____

If the patient is a minor, give parent or guardian's name: ____________________

Group # ____________________

Employer ____

Insurance Company _____________________________________

Insurance Company Phone # ______________________________________

Dental History and Preferences:

What is your reason for today's visit (jaw pain, tooth pain, just need a cleaning, etc)?

____

____

Tell us, in your opinion, what you think the present state of the health of your mouth is?

____

See back page □

How healthy do you want us to get your mouth?

Don't really care **Average** **The best it can be**

Should you need treatment, at what point do you prefer we address it? (Please circle one)

When my tooth hurts **When something is worsening** **When something isn't ideal**

Has fear ever been an issue for you in a dental office? ______________________________

Has time ever been a factor in getting your dental work done? _______________________

What caused you to leave your last dentist? ____

How long has it been since your last dental cleaning? _________________________________

Have you ever been told you have gum disease? ____________________

Are you happy with the appearance of your smile? (yes) (no)

Would you like to have whiter teeth? (yes) (no)

Would you like to have straighter teeth? (yes) (no)

How often do you brush your teeth? _________________________

Do you floss?____________If yes, how often? _____________________________

Do you use a fluoride toothpaste at home?________Do you prefer to avoid fluoride? ________

Do you allow us to take dental x-rays at the dentist's discretion?__________If no, please give details about your preferences:____.

Please check if you have any of the following:

__Bad breath	__Bleeding gums	__Loose teeth
__Food trapped in teeth	__Grinding/Clenching	__Sensitive to hot
__Broken fillings	__Periodontal treatment	__Sensitive to cold
__Sensitive to sweets	__Sensitive to biting	__Sores in mouth
__Staining	__Clicking or popping jaw	__Jaw pain

Would you like us to perform an advanced oral cancer screening* on you today? (yes) (no)

*The dentist and/or hygienist will always perform a ***visual*** oral cancer screening, the current standard of care, at no additional charge as part of a complete exam. The ***advanced*** oral cancer screening utilizes a special fluorescent light that can help detect cellular changes earlier than with the naked eye. If your dental insurance does not reimburse for this, the cost is $20.

Would you be interested in flexible financing options to help pay for your dental treatment today?

____

Medical History

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies or Sensitivities:

Acrylics Y N
Codeine Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulfa Y N
Fragrances or chemicals Y N
Other Y N
List other allergies or sensitivities:

____
____
____

Autoimmune:

Hashimoto's Y N
Rheumatoid arthritis Y N
Crohn's disease Y N
Ulcerative colitis Y N
Celiac disease Y N
Lupus Y N
Sjogren's syndrome Y N
Type 1 diabetes Y N
Psoriasis Y N
Multiple sclerosis Y N
Ankylosing spondylitis Y N
Other autoimmune (specify) Y N

Cardiovascular:

Artificial heart valve Y N
Coronary artery disease Y N
Chest pain or angina Y N
Congestive heart failure Y N
Heart attack Y N
Heart murmur Y N
High blood pressure Y N
High cholesterol Y N
Irregular heart beat Y N
Low blood pressure Y N
Men:Erectile dysfunction Y N
Mitral valve prolapse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine:

Diabetes Y N
Gout Y N
Hormonal problems Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat:

Change in hearing Y N
Change in vision Y N
Dysphagia/difficulty swallowing Y N
Ear pain Y N
Glaucoma Y N
Hay fever Y N
Seasonal allergies Y N
Sinus problems Y N
Tonsillectomy Y N
Tinnitus Y N
White coating on tongue Y N

Gastrointestinal:

Acid reflux Y N
Soft or special diet Y N
Stomach ulcers Y N

Hematological:

Bleeding problems Y N
Hepatitis Y N
Herpes Y N
HIV/AIDS Y N
Liver problems Y N

Musculoskeletal:

Back pain Y N
Fibromyalgia Y N
Joint pain Y N
Joint replacement Y N
Arthritis Y N

Neurological:

Alzheimer's disease Y N
Brain fog Y N
Dizziness Y N
Fainting Y N
Memory loss Y N
Multiple sclerosis Y N
Muscle weakness Y N
Seizures Y N
Stroke Y N
Tingling/numbness Y N
Trigeminal neuralgia Y N
Tremor Y N

Psychiatric:

ADD/ADHD Y N
Anxiety Y N
Chemical dependency Y N
Depression Y N
Eating disorders Y N
Excessive stress Y N
Fatigue/tired Y N
Memory problems Y N

Respiratory:

Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest pressure Y N
Dyspnea (shortness of breath) Y N
Emphysema Y N
Orthopnea (shortness of breath when lying flat) Y N
Pneumonia Y N
Pulmonary embolism Y N
Tuberculosis Y N

Sleep:

Daytime sleepiness Y N
Morning headaches Y N
Sleep apnea Y N
Do you use CPAP? Y N
Snoring Y N

General:

Current approx. weight:____lbs
Height: _________
Weight change Y N
Cancer Y N
Radiation treatment Y N
Do you smoke? Y N
Smokeless tobacco Y N
Recreational drugs Y N

Are you pregnant? Y N
Trying to conceive? Y N
Pregnancy complications Y N
Miscarriage Y N
Difficulty conceiving Y N
Are you breastfeeding? Y N

List any medications, vitamins or supplements you are taking. Include prescription and over-the-counter.

______________________ ________________________ _____________________
______________________ ________________________ _____________________
______________________ ________________________ _____________________

Please list any surgeries or hospitalizations you have had.

____
____
____

Please list and detail any medical condition or history not listed previously.

____
____
____

Date of last ***medical*** exam: ______________________

What was the exam for?______________________Current physician ***(medical doctor)***: __________________

Do you see any other physicians or naturopathic healthcare providers (medical specialists, chiropractors, nutritionists, etc)? If so, please list name(s) and reason(s).

____

Do you have a family history of:
Diabetes (type 1 or 2)? __________________
Heart disease, high blood pressure, heart attack or stroke? ________________________
Cancer? _________________________
Alzheimer's? ______________________

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

I have read and agree to abide by the practice policies above.

____
Signature of patient/parent/guardian Date

Practice and Financial Policies

Patient Name: ____

Thank you for choosing Legacy Dentistry as your dental care provider. Dental treatment is an excellent investment in your overall health and wellbeing, and our goal is to help you fit these services into your budget and lifestyle. Therefore, if you have any questions or concerns about our policies, or if your dental needs place an exceeding burden on your finances, please to not hesitate to speak to our office manager.

1. Payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and CareCredit financing. If using dental insurance, payment of your ***estimated*** patient portion, along with any deductible or co-payment, is due at the time of treatment. A deposit will be required to schedule an appointment that is 2 hours or longer.
2. We will process your insurance claim as a courtesy to you, as long as you provide us with adequate information.
3. Our goal is to optimize your oral and overall health. An insurance carrier's goal is to control costs and maximize profits for shareholders. Please remember that what is best for your health is not necessarily the same as what your benefits will cover.
4. Insurance companies do not always pay the exact amount they say they will; therefore, all treatment plans include an ESTIMATE ONLY of what your plan will contribute.
5. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
6. All charges are your responsibility, regardless of whether your insurance company pays. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.
7. If the insurance company does not pay within 45 days, we require you to pay the balance due with cash, check, or credit card.
8. You are responsible for notifying us of any changes in address, job status, insurance status, or availability of benefits as soon as possible. Failure to do so may result in a balance on your account, for which you will be responsible.
9. We often reserve appointments well in advance, so failure to make your scheduled appointment is not only unfair to the practice, but to other patients as well. Therefore, we may ask that you pay for longer appointments in advance, in order to reserve your place on our schedule.
10. Please let us know as soon as possible if you cannot make your appointment. **Failure to inform us at least 24 hours in advance will result in a cancellation fee of $50 per hour of your appointment.** If you are more than 15 minutes late, we may have to reschedule your appointment. We will try to see you if possible, but on-time patients may be seen ahead of you.

I have read and agree to abide by the practice policies above.

____

Signature of patient/parent/guardian Date

Meet Your
Dental Family

OUR DOCTOR

Meet Dr. Tony Nguyen

From the very first appointment, Dr. Nguyen's patients will see just how passionate he is about partnering with them to help their biggest dental and esthetic goals become a reality. His personable, down to earth attitude goes a long way towards putting new arrivals at ease, and he always makes it a priority to create a comfortable atmosphere that's free of anxiety. He looks forward to helping you lead a healthier, happier life!