



DR. TIOLE NGUYEN
DR. CHRISTOPHER GONZALES

NEW PATIENT INFORMATION:

Please fill in all information to the best of your knowledge

Patient Name: _____ *

Date of Birth: _____ *

Social Security Number: _____ *

License Number: _____ *

Address: _____ *

City: _____ *

State: _____ *

Zip: _____ *

Male *

Female

Email: _____ *

Cell Phone: _____ *

Emergency Contact Name and Phone Number: _____

How did you hear about us? _____ *

Employer Name: _____

Insurance Company Name: _____

If the patient is not the insurance policy subscriber, please provide subscriber information below:

Subscriber's Name: _____

Subscriber Date of Birth: _____

Subscriber's Social Security Number: _____

Subscriber's Employer: _____

Relation to Subscriber: _____

Medical History: *

Are you under physician's care now? _____

Are you taking any medications?

Are you or have you taken any bisphosphonates? _____

WOMEN: Are you pregnant/nursing? _____

Are you allergic to any of the following?

(Aspirin // Penicillin // Codeine // Acrylic // Latex // OTHER : _____)

Do you have any of the following?

AIDS/HIV	HERPES (COLD SORES)
ALZHEIMER'S	HIGH BLOOD PRESSURE
ARTHRITIS	HIGH CHOLESTEROL
ARTIFICIAL HEART VALVE	HYPOGLYCEMIA
ARTIFICIAL JOINT	KIDNEY PROBLEMS
ASTHMA	LEUKEMIA
BLOOD THINNER	LIVER DISEASE
CANCER/CHEMOTHERAPY	LOW BLOOD PRESSURE
DIABETES	LUNG DISEASE
EMPHYSEMA	OSTEOPOROSIS
HEART DISEASE	PAIN IN JAW JOINTS
HEPATITIS A, B OR C	SINUS TROUBLE

Do you have any other serious illnesses 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 status.

X _____ DATE: _____



PAYMENT POLICY:

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** For treatment involving fees above \$500.00, special financial arrangements may be discussed with our financial coordinator or office administrator. Please note that broken payment plan arrangements will disqualify you from future payment arrangements.
- For patients with Dental Insurance:
 1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
 2. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
 3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
 4. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
 5. **After 90 days, if insurance claims are not resolved, the balance becomes patient's responsibility**
- Please note: for your convenience, we do accept VISA, MasterCard, Discover, American Express, Apple Pay, Lending Club and Care Credit as well as personal checks and cash.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on 30 day overdue balances, 3% on 60 day overdue balances, and 6% on 90 day overdue balances.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature: _____

Date: _____



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GENERAL CANCELLATION AND NO SHOW POLICY:

We understand your time is valuable, therefore when scheduling we reserve this time specifically for you to minimize your time in the office, with little to no wait time. We understand that situations may arise that will keep you from making it to your appointment. We are asking that you please help us maintain an efficient schedule. If you are not able to make it to your appointment, we require **24 hours' notice**, or a **\$50** cancellation fee will be charged to your account. Cancellations must be made by phone or by email to our front office.

Due to the high demand of Saturday and lengthy appointments, we ask you give us **72 hours' notice**. Any treatment appointment made that exceeds \$500 will require 20% down to hold the appointment time. This amount will be deducted from the cost of the treatment when you come for your appointment. A **72 hours' notice is required** if you need to cancel or reschedule your appointment in order to avoid a fee being assessed. If you do not cancel in that time frame, your account will be charged **\$100.00**. *Multiple no shows or cancellations without notice can result in a loss of Saturday scheduling privileges or being dismissed as a continuing patient with us.*

*** You may call after hours and leave a voicemail. Dr. Nguyen answers and checks the voicemail regularly ***

Signature: _____

Date: _____

PRIVACY POLICY:

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 469-616-0488.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. *360 Family and Implant Dentistry* does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

360 Family and Implant Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with *360 Family and Implant Dentistry*.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy *360 Family and Implant Dentistry* occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

List any Family Members you wish us to disclose your treatment info to:

- 1. _____
- 2. _____
- 3. _____

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I, _____, have reviewed **360 Family and Implant Dentistry's** Privacy Policy.

Signed: _____ Date: _____

Patient's Name (please print): _____



CONSENT TO DENTAL PHOTOGRAPHY

Dr. Gonzales (and Dr. Nguyen) will sometimes want to take photos of your teeth, especially if it is a cosmetic or interesting case. You can always request copies of the photos we take of your case.

I, _____, authorize 360 Family & Implant Dentistry, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your pictures used for any of the above purposes

Patient's Name: _____

Patient's Signature: _____

Date: _____