PATIENT INFORMATION

Cypress Dental
Dr. Brian Chan, D.M.D

Welcome to the office of Dr. Brian Chan!

PERSONAL INFORMATION:

First Name:_____ Last Name:_____ SS#:_____

Address_____
Street City State Zip

Telephone: Home_____ Business_____ Cell_____

Current E-mail Address: _____

Birth date:_____ Sex: _____ Marital Status:_____ Spouse Name:_____

Employer:_____ Job Title:_____

Employer Address: _____

Primary Dental Insurance:

Name of Insured/Subscriber: _____ Relationship to Patient:_____

DOB of Insured/Subscriber:_____ Insured/Subscriber SSN:_____

Address of Insured:_____ Phone#:_____

Name of Employer:_____ Insurance Company Name: _____

Ins Co. Address:_____ Group #:_____

Insurance Card ID #: _____ Ins. Phone #: _____

Secondary Dental Insurance:

Name of Insured/Subscriber: _____ Relationship to Patient:_____

DOB of Insured/Subscriber:_____ Insured/Subscriber SSN:_____

Address of Insured:_____ Phone#:_____

Name of Employer:_____ Insurance Company Name: _____

Ins Co. Address:_____ Group #:_____

Insurance Card ID #: _____ Ins. Phone #: _____

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Personal Primary Care Physician:_____Phone#:_____

Emergency Contact:_____Phone #:_____

DENTAL HISTORY

Previous Dentist: _____Phone#: _____

Date of Last Appointment:_____Date of last x-rays:_____

Why did you leave your previous dentist?_____

What is the purpose of your visit today?_____

Are you having discomfort today? If yes, please explain_____

_____

Have you ever had joint popping, locking, clicking, pain, etc? If yes, please explain_____

_____

Have you ever had orthodontics, periodontal surgery, oral surgery? If yes, please explain_____

_____

What do you expect of us to help meet your dental goals?_____

Do you like your smile? If no, please explain_____

How did you hear about our office?_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all the above answers and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I also understand that payment is expected the same day services are rendered unless prior financial arrangements have been made with the office manager. If you have insurance we will gladly help you process your claims but we require that you pay your estimated portion the day services are rendered.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Brian Chan DMD. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. I consent to the use and disclosure of my protected health information to carry out payment activities in connection with my dental claims.

Signature:_____Date:_____

Cypress Dental

Dr. Brian Chan

Financial Contract/Agreement

- I understand that if I do not pay my account with Dr. Brian Chan in full that my account may be assigned to a collection agency for collection.
- I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission fee that may be as much as 50% of the amount that I owe Dr. Chan. I agree that if my account is assigned to a collection agency, that Dr. Chan may add the amount of the collection agency's commission of fee to the amount that I owe Dr. Chan, and I agree to pay that additional amount.
- I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services. I understand, for example, that if the unpaid balance that I owe to Dr. Chan is $1000 that Dr. Chan may add up to $500 to my account, and I agree to pay the sum of $1500 in such event.
- I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

SIGNATURE_____ **DATE**_____

Patient Consent/ Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. Brian Chan, our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosure for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (775) 825-8366 and requesting a revised Notice. We will also post any revised notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI). THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT. I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

SIGNATURE_____ **DATE**_____

A SIGNATURE IS NEEDED FOR EACH MEMBER OF THE FAMILY. CHILDREN UNDERTHE AGE OF 18 MUST HAVE A PARENT/GUARDIAN SIGNATURE

Cypress Dental

Dr. Brian Chan
6880 S McCarran Blvd. #9
Reno, NV 89509
Phone (775)825-8366

Cancellation Policy

We understand that sometimes appointments may need to be rescheduled. We require that you give our office at least Two (2) Business Days Notice if you will be unable to keep your scheduled appointment. We will at that time help to find a better time/date to accommodate you and then reschedule your appointment.

If you are unable to give us Two (2) Business Days Notice you will be charged a fee of $45.00. We reserve specific amounts of time in our schedule for our patients, ensuring them that they will get the proper treatment and care during that time. Our patients are very valuable to us, as is our time with them. We ask that you please be considerate to this.

Signature X_____Date _____

Photograph Authorization

As a Patient of Dr. Brian Chan, I hereby authorize Dr. Chan to take photographs of my dental conditions. These photos will be used for diagnostic purposes and treatment records. I further understand that any photographs taken by Dr. Chan or his staff will remain the property of Dr. Chan.

Signature X_____Date: _____

Cypress Dental

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Are you under a physician's 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: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	EasilyWinded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____