

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Information _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ Male Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Primary contact number (please check one) Home Work Cell Best time to call _____

Fax (____) _____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? Google Yelp Internet Valpak Patient Name _____

If the patient is a child

School _____ School phone (____) _____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? Yes No
If so, please describe: _____

Do you have any dental problems now? Yes No
If so, please describe: _____

Have you ever had trouble with a previous dental treatment? Yes No
If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (____) _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? Hard Medium Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had:

- | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Periodontal disease/gum treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Discomfort in your jaw joint (TMJ/TMD)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orthodontics treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Your teeth ground or bite adjusted | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oral surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Serious injury to the mouth or head | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A bite plate or mouth guard | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatments that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? Yes No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? Yes No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) Yes No

If yes, please explain _____

Have you ever taken Feh-Phen? Yes No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? Yes No

If so, what are the problems? _____

Do you use tobacco? Yes No **Do you use alcohol or any other controlled substance?** Yes No

Women only:

Are you pregnant or think you may be pregnant? Yes No Are you nursing? Yes No

Are you taking birth control pills? Yes No

Indicate which of the following you have had or have at present?

- | | | | | | | | | |
|---------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol/Drug Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies or Hives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervousness/Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric/ | | |
| Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychological Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Bones/Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic/Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles/Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease/Traits | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer/Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A B C (circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Snoring/Sleep Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High or Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach Problems/Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold Sores/Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hospitalized for Any Reason | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Colitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contact Lenses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | Tumors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diet (Special/Restricted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | Venereal Disease/STD | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- | | | | | | | | | |
|------------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sedatives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Codeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jewelry/Metals | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sulfa Drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anesthetics (i.e. Novocaine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Erythromycin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin or Other Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |

Patient signature _____

Today's date _____

Patient Number _____

1. Do you love the way your smile looks? Yes No
2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No
3. If you could change anything about your smile, it would be (check all that apply):

<input type="checkbox"/> Color of your teeth	<input type="checkbox"/> Too much or too little of teeth show when you smile	<input type="checkbox"/> Gaps between your teeth
<input type="checkbox"/> Size/Shape of your teeth	<input type="checkbox"/> Too much or too little of gum shows when you smile	<input type="checkbox"/> Alignment of your teeth
<input type="checkbox"/> Other: _____		
4. Do you have (check all that apply):

<input type="checkbox"/> Sensitive or receding gums	<input type="checkbox"/> Wom/broken/chipped teeth	<input type="checkbox"/> Old or discolored fillings	<input type="checkbox"/> Missing teeth
<input type="checkbox"/> Old crowns that have dark edges at the top			
<input type="checkbox"/> Other: _____			
5. In your line of work or lifestyle, do you (check all that apply):

<input type="checkbox"/> Visit businesses or clients	<input type="checkbox"/> Travel	<input type="checkbox"/> Speak publicly	<input type="checkbox"/> Other: _____
--	---------------------------------	---	---------------------------------------
6. If you had a smile makeover do you think you'd feel (check all that apply):

<input type="checkbox"/> More confident	<input type="checkbox"/> More optimistic	<input type="checkbox"/> Healthier
<input type="checkbox"/> Just OK	<input type="checkbox"/> No different	<input type="checkbox"/> Other: _____
7. Do you or someone in your family have issues with any of the following (check all that apply):

<input type="checkbox"/> Chronic bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Snoring
<input type="checkbox"/> Other: _____		

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

<input type="checkbox"/> Early morning	<input type="checkbox"/> Early afternoon	<input type="checkbox"/> No preference
<input type="checkbox"/> Late morning	<input type="checkbox"/> Late afternoon	<input type="checkbox"/> Other: _____
9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

10. What type(s) of music do you enjoy? (check all that apply)

<input type="checkbox"/> Easy Listening	<input type="checkbox"/> Classical	<input type="checkbox"/> Rock	<input type="checkbox"/> Hip-Hop/Rap
<input type="checkbox"/> Jazz	<input type="checkbox"/> Country	<input type="checkbox"/> R&B	<input type="checkbox"/> Other:
11. What are your favorite hobbies or activities?

12. Do you have children and grandchildren? If so, please list their names and ages.

13. Is there anything else that you want our office to know about you that will help us to serve you better?

Anding Family Dental, P.C.
4702 Lafayette Avenue.
Omaha, NE 68132
Ph: (402)933-4631 Fax: (402)933-5236

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent I write at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Michelle Chang, DDS

Financial Policy

Welcome to Anding Family Dental P.C.. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available.

- We know that providing complete comprehensive dental services includes discussing all treatment and financial information. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, money orders or registered checks. Care Credit may also be available to you. No credit check, flexible payment, guaranteed financing option also available after your first appointment.

- Clients new to our practice without dental insurance should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.
- Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits is your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.
- Any deductible or estimated co-payment amount will be due at the time of treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.
- Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if opening arise. We reserve the right to charge and collect \$75.00 for any broken appointments. Broken appointments are considered those that are missed (no-show) and cancelled with less than 24 hour advance notice. Breaking more than 1 appointment with Anding Family Dental, P.C. may result in dismissal from the practice.
- Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

Patient Signature: _____ Date: _____