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: ____________________________

Pediatric Medical History

Patient Name: _______________________________ Birth Date: _____________________

Is your child under the care of a physician now? ☐ Yes ☐ No

If yes, please explain: ____

Does your child have any allergies (i.e. food, medication, etc.)? ☐ Yes ☐ No

Are there any family history of allergies to medications? ☐ Yes ☐ No

If yes, please explain: ____

Is your child taking any medications including over the counter medication? ☐ Yes ☐ No

If yes, please explain: ____

Is your child's immunization current? ☐ Yes ☐ No

Is your child taking antibiotics before having dental treatment? ☐ Yes ☐ No

Has your child had any serious illness? ☐ Yes ☐ No

Has your child ever been hospitalized or an emergency room visit ☐ Yes ☐ No

If yes, please explain: ____

Does your child have any habits (i.e. thumb sucking, bottle, pacifier, etc.)? ☐ Yes ☐ No

If yes, please explain: ____

Please check if your child has a history of or has been treated for any of the following:

☐ Abuse	☐ Congenital Birth Defects	☐ Physical Delay
☐ ADD/ADHD	☐ Diabetes	☐ Recurrent Headaches
☐ Adverse Drug Reaction	☐ Emotional Problems	☐ Rheumatic Fever
☐ Anemia	☐ Endocrine Disorder	☐ Seizures
☐ Arthritis	☐ Frequent Infection	☐ Sickle Cell Disease
☐ Asthma	☐ Heart Disease	☐ Speech/Hearing
☐ Autism	☐ Heart Murmur	☐ Speech/Hearing
☐ Bleeding/Transfusion	☐ Hepatitis	☐ Spina Bifida
☐ Blood Dyscrasias	☐ HIV/AIDS	☐ TB
☐ Cancer	☐ Kidney Disease	☐ Tonsil/Adenoid Problems
☐ Cerebral Palsy	☐ Liver/GI Disease	☐ Vision Problems
☐ Cleft/Lip Palate	☐ Mental Delay	☐ Other: _____________

Additional Comments/Illness not listed above:

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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 child'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.

In this agreement, the words “you”, “your”, and “yours” means the patient/debtor. The word “account”, means the account that has been established in the patient’s name to which charges are made and payments are credited. The word “we”, “us” and “ours” refers to your treating dentist; Nguyen M. Tau or Nguyet M. Tau at Happy Teeth Dental Care, PC.

By executing this agreement, you agree to the terms of the financial agreement and agree to pay for all services that are received.

_______________________________________ ____

Patient Name (Please Print) Date

______________________________________ ____

Responsible Party/Guardian (Please Print) Responsible Party/Guardian (Signature)