So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Patient Information

Patient Name ____
Last, First MI (Preferred Name)

Gender ______ Marital Status ___________ Social Security # ________ Birth Date ______________________

Phone (Home) (____) _______________ (Work) (____) _______________ Ext _____ (Cell) ______________

Best time to call _________________ E-mail ______________________________________

Address ____
Street City State Zip Code

Whom may we *THANK* for referring you to our practice?

____

Responsible Party Information

The following is for ☐ The Person Responsible Payment. ☐ The Patient's Spouse

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security # ______________________ Birth Date ______________________

Phone (Home) (____) _______________ (Work) (____) _______________ Ext ________ Best time to call ________

Address ____
Street Apartment # City State Zip Code

____
Employer Name Occupation Employer Phone

Insurance Information

Primary

Name of Insured ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _________________ ID #_________________ Group # _________________

Insured's Address ____
Street City State Zip Code

Insured's Employer Name ____

Address ____
Street City State Zip Code

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address ____

____

Secondary

Name of Insured ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _________________ ID #_________________ Group #_________________

Insured's Address ____
Street City State Zip Code

Insured's Employer Name ____

Address ____
Street City State Zip Code

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address ____

____

Treatment Consent: I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all mutually agreed treatment upon me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand payment is due at the time of service unless

other arrangements have been made. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor or appropriate staff member of any change in my health or medication.

Photo Consent – I hereby give consent for Dr. Jonathan Vongschanphen, DDS, LVIF to take and/or display photograph(s) of the face and teeth/smile of me. The photograph(s) will be used for educational and/or advertising purposes by Dr. Jonathan Vongschanphen, DDS, LVIF and may be displayed within our office and/or on the dental office's webpage at www.Drjondds.com, Dr. Vongschanphen's office and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content and further agree to consent for dental treatment.

Emergency Contact

In Case of Emergency, the following person will be called.

Name ______________________ Phone ______________________ Phone ______________________

X ______________________ Print Name ______________________ Date ______________
Signature of Patient, Parent or Guardian (if under the age of 18 years old)

X ______________________ Print Name ______________________ Date ______________
Signature of Guarantor of Payment or Responsible Party

Both forms below may be downloaded on Dr. Vongschanphen's Website where this form was printed.

I have received a copy of the Dental Board of California's Dental Materials Fact Sheet.

X ____ Date ______________
Signature of Patient, Parent or Guardian (If under the age of 18 years old)

I have received a copy of the Financial & Assignment of Benefits Agreement.

X ______________________ Print Name______________________ Date ______________
Signature of Patient, Parent or Guardian (If under the age of 18 years old)

I have received a copy of the HIPAA Notice of Privacy Practices.

X ______________________ Print Name______________________ Date ______________
Signature of Patient, Parent or Guardian (If under the age of 18 years old)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining acknowledgment
- ☐ Other ______________________________

X ______________________ Print Name______________________ Date ______________
Signature of Employee

Appointment Appreciation Policy

Your appointment is a time that has been set aside exclusively for you. We understand that your time is very valuable, and in an effort to respect *your* time and that of our other patients, we require a ***TWO BUSINESS DAY*** notice to change or cancel your appointment. We understand that things can come up last minute from time to time, however, last minute cancellations and no shows may be subject to a $50 cancellation fee.

Thank you, The Team at Dr. Jon's Office

X ______________________ Print Name______________________ Date ______________
Signature of Patient, Parent or Guardian (If under the age of 18 years old)