

# WELCOME TO DC DENTAL SPA

## 1 About You

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Name you prefer to be called \_\_\_\_\_  
Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Work # \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_  
Referred by \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_  
Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Minor \_\_\_  
Spouse's Name \_\_\_\_\_  
Children? \_\_\_\_\_ If Yes, How Many \_\_\_\_\_

## 2 Account Responsibility

Patient Name \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS# \_\_\_\_\_  
Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
Work # \_\_\_\_\_  
Payment Method: Cash \_\_\_\_\_ Check \_\_\_\_\_ CC \_\_\_\_\_  
Credit Card \_\_\_\_\_ Visa \_\_\_\_\_ MC \_\_\_\_\_ AMEX \_\_\_\_\_ Disc. \_\_\_\_\_

\_\_\_\_\_(Initials) I hereby authorize assignment of my insurance rights and authorize benefits to be paid directly to the provider for any services rendered. I fully understand I am solely responsible for any charges or balances not paid by my insurance company (if offered at this office).

## 3 Insurance Info

### Primary Dental Insurance

Co. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_  
Insured's SS# \_\_\_\_\_  
Group/Policy # \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

### Secondary Dental Insurance and/or Medical Insurance

Co. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_  
Insured's SS# \_\_\_\_\_  
Group/Policy # \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

## 4 Emergency Contact

Emergency Contact #1 \_\_\_\_\_  
Emergency Contact #2 \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Contact #1 Work \_\_\_\_\_ Cell \_\_\_\_\_  
Contact #2 Work \_\_\_\_\_ Cell \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_

PLEASE CONTINUE ON BACK → → →

# 5 Dental Information

Reason for today's visit: Exam \_\_\_\_\_ Cleaning \_\_\_\_\_ Consultation \_\_\_\_\_ Emergency \_\_\_\_\_

Other \_\_\_\_\_

Are you in pain? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, How Long \_\_\_\_\_

Please indicate in the space provided with an "X" if you have any of the following problems:

_____ Discomfort, clicking or popping in the jaw	_____ Lost/Broken filling	_____ Stained teeth
_____ Red, swollen or bleeding gums	_____ Teeth grinding	_____ Locking jaw
_____ Sensitive tooth/teeth or gums	_____ Ringing in ears	_____ Bad breath
_____ Blisters/Soars in or around the mouth	_____ Broken/Chipped tooth	
_____ Other _____		

Do you require pre-medication? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know

Previous Dentist Name \_\_\_\_\_ Phone # \_\_\_\_\_

Times a day you brush your teeth \_\_\_\_\_ Times a day you floss \_\_\_\_\_ Do you use a water pik? \_\_\_\_\_

What type of tooth brush bristles do you use \_\_\_\_\_ Soft \_\_\_\_\_ Medium \_\_\_\_\_ Hard

Please rate your smile (1 being low) 1 2 3 4 5 6 7 8 9 10 Happy with overall look of your teeth \_\_\_\_\_ Yes \_\_\_\_\_ No

# 6 Medical History

Are you taking any of the following medications \_\_\_\_\_ Nerve pills  
\_\_\_\_\_ Pain killers \_\_\_\_\_ Muscle relaxers \_\_\_\_\_ Insulin  
\_\_\_\_\_ Blood thinners \_\_\_\_\_ Tranquilizers \_\_\_\_\_ Other : \_\_\_\_\_

Do you have, or have ever had any of the following diseases or medical conditions?

Y N Heart Attack/Stroke	Y N Kidney Problems	Y N Shingles	Y N Asthma or Bronchitis
Y N Heart Surgery/Pacemaker	Y N Liver Problems	Y N Hepatitis	Y N Difficulty Breathing
Y N Hear Murmur	Y N Sinus Problems/Migraines	Y N HIV+/AIDS/ARC	Y N Diabetes or Hypoglycemia
Y N Rheumatic Fever	Y N Arthritis/Rheumatism	Y N Leukemia or Lymphoma	Y N Stomach Problems/Ulcers
Y N Mitral Valve Prolapse	Y N Psychiatric Problems	Y N Artificial Bones/Joints	Y N Anemia
Y N Artificial Valves	Y N Venereal Disease	Y N Emphysema	Y N High/Low Blood Pressure
Y N Heart Disease	Y N Alcohol/Drug Abuse	Y N Tuberculosis (TB)	Y N Severe/Frequent Headaches
Y N Congenital Heart Defect	Y N Frequent Neck Pain	Y N Back or Spine Problems	Y N Jaw Problems/TMJ/TMD
Y N Scarlet fever	Y N Chest Pain	Y N Glaucoma	Y N Fainting/Seizures/Epilepsy
Y N Bleeding Problems	Y N Cancer or Tumors	Y N Chemotherapy	

Other medical condition(s) you have - or have ever had: \_\_\_\_\_

Are you allergic to any of the following \_\_\_\_\_ Latex \_\_\_\_\_ Pencillin/Amoxicillin \_\_\_\_\_ Aspirin \_\_\_\_\_ Dental Anesthetics

Others: \_\_\_\_\_

Do you use Tobacco \_\_\_\_\_ Yes \_\_\_\_\_ No How many packs \_\_\_\_\_ How Long \_\_\_\_\_

Do you wear \_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses

Women Only: Are you taking birth control pills \_\_\_\_\_ Yes \_\_\_\_\_ No How many children have you had \_\_\_\_\_

Please rate your overall general (1 being low) 1 2 3 4 5 6 7 8 9 10

We invite you to discuss with us any question regarding this form and our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for services rendered at the time of your visit unless other financial arrangements have been made with our business manager. If account is not paid within 90 days of the date of service, and no financial arrangements have been authorized, you will be responsible for collection agency fees, legal fees and any interest/late fees accrued. I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process any insurance claims. I understand the above information and warrant/guarantee this form, and the information contained within, is true and correct to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Adult Patient \_\_\_\_\_ Parent or Guardian \_\_\_\_\_ Spouse

# Financial and Office Policies

*(Please read carefully before signing)*

Dr. Rex H. Hoang, DMD, PC

1325 18th St., NW, Ste. 203, Washington DC 20036

(202) 833-8724

- Our office is dedicated to your care and comfort by providing the best possible client service.
- All patients must complete our information forms before seeing the doctor. A picture ID is also required.
- We accept cash, checks and most major credit cards (accompanied by a driver's license and major credit card). We also offer other financing options (please speak to our financial coordinator). DC Dental Spa will accept any/all payments from any/all insurance companies.

## Insurance Policy:

You will be informed of the exact costs for any procedures that will be performed. You are ultimately responsible for the full amount incurred. As a courtesy to you, we will file all the necessary paperwork to insurance companies, and we will accept all insurance payments from any/all companies. We kindly remind you that your insurance policy is a contractual agreement between you and the insurance company. DC Dental Spa is not a party to that contract.

## Financing Policy:

By utilizing Care Credit Financing, you will be subject to a 5% cancellation service fee.

## Usual and Customary Rates:

Our dental practice is committed to providing the best treatment for our patients, and our prices reflect our commitment to quality and our location in the Washington, DC area.

## Guarantee of Services:

Dr. Hoang and the staff of DC Dental Spa take great pride in the quality of their work. All major treatments will come with a 5-year warranty, commencing from the date of the service and/or treatment provided. Please Note: The warranty is only applicable if the patient has adhered to all scheduled 6-month re-care examinations.

## Missed Appointments:

DC Dental Spa requests a 10% deposit, or \$75 (whichever is greater), towards your treatment when reserving time with our doctors and/or staff for your next appointment. This will ensure that you receive 100% of the doctor's time and attention. In an effort to accommodate all of our patients, all cancellations and rescheduling of appointments must be made 48 hours in advance - and only during business hours. In the event of a late cancellation (less than 48 hours of notice), your deposit will be applied as a "missed appointment fee".

## Collection Accounts:

Only utilized as a last resort, collection procedures shall be implemented for seriously past due accounts. Please discuss your balance and payment options with our financial coordinator. If it becomes necessary to forward your account to a collection agency, you will be responsible for all accrued applicable interest, collection fees, and possible attorney fees.

Thank you for reading our Financial and Office Policy. Please let us know if you have additional questions or concerns regarding these policies.

I have read the above, and I understand and agree to the terms and conditions of this Financial and Office Policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Adult Patient \_\_\_\_\_ Parent or Guardian \_\_\_\_\_ Spouse

# DC Dental Spa

1325 18th St., NW, Ste. 203, Washington DC 20036

Call (202) 833-8724

Dr. Rex H. Hoang, DMD, PC

dcdentalspa.com

## CONSENT TO DENTAL TREATMENT

I (print name) \_\_\_\_\_ have been informed by Dr. Rex Hoang, DMD, PC, of the need to undergo dental treatment as present to me on \_\_\_\_\_.

I have been fully informed about the details of the recommended treatment and alternatives, and agree to accept the treatment as recommended by the doctor.

I understand that as the treatment proceeds, there may be a need to change the treatment plan. If this occurs, I expect to be informed before the change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated and unexpected reactions during or following any treatment, I agree to report them to DC Dental Spa as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following post care protocols, following home care instructions, including good oral hygiene and dietary instructions. I further agree to report to the office any changes in my health status as soon as possible.

I have discussed all of the above with the Doctor, and all of my questions have been answered.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanation, the discussion, and the answers to my questions, I authorize the Doctor to complete the treatment and/or procedure as described.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
If a Minor, Signature of Parent or Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date

# Consent for Use and Information Disclosure of Health Information

Dr. Rex H. Hoang, DMD, PC

1325 18th St., NW, Ste. 203, Washington DC 20036

(202) 833-8724

## SECTION A: PATIENT GIVING CONSENT

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Patient Number \_\_\_\_\_ Social Security # \_\_\_\_\_

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment options and activities, as well as health care options.

**Notice of Privacy Practice:** You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this consent. Our *Notice* provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our *Notice* accompanies this consent. We encourage you to read it carefully and completely before signing this *Consent*.

We reserve the right to change our privacy practices as described in our **Notice of Privacy Practices**. If we change our privacy practices, we will issue a revised **Notice of Privacy Practices**, which will contain the change. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our **Notice of Privacy Practices**, including any revisions of our *Notice*, at any time by contacting:

Office Manager

(202) 833-8724 Fax: (202) 833-8725

1325 18th St., NW, Ste. 203, Washington DC 20036

Email: drrexhoang@dcdentalspa.com

**Right to Revoke:** You will have the right to revoke this Consent for Use and Information Disclosure of Health Information by giving written notice of your revocation submitted to the contact person noted above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Acceptance and Signature:

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_