



mill creek dental

DR. NIKKI CHIN

New Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Gender: ____ Age: _____

Preferred name: _____ Date of birth: _____

Home address: _____

Street

City

State

Zip

Billing address: _____

(if different)

Street

City

State

Zip

Home phone: _____ Cell: _____

E-mail: _____

SS #: _____ Employer/Occupation: _____

Spouse's name: _____ Phone Number: _____

Who may we thank for referring you? _____

Insurance Information

Primary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

Secondary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

Name: _____

Dental History

- | | |
|--|---|
| Y N Are you apprehensive about dental care? | Y N Do you take fluoride supplements? |
| Y N Have you had problems with previous treatment? | Y N Are you dissatisfied with the appearance of your teeth?
What do you dislike about your teeth/smile?
_____ |
| Y N Do you gag easily | _____ |
| Y N Do you wear dentures? | Y N Does your jaw make noise that bothers you or others? |
| Y N Does food catch between your teeth? | Y N Do you clench or grind your jaws frequently? |
| Y N Do you have difficulty chewing your food? | Y N Does your jaw get stuck so that you can't open freely? |
| Y N Do you avoid brushing any part of your mouth? | Y N Does it hurt when you chew or open wide to take a bite? |
| Y N Do your gums bleed easily? Feel swollen or tender? | Y N Do you have any jaw symptoms or headaches after waking? |
| Y N Have you noticed slow-healing sores in your mouth? | Y N Do you have a temporomandibular (jaw) disorder? |
| Y N Are your teeth sensitive? | Y N Do you have pain in the face, cheeks, jaws, joints, temples? |
| Y N Does your mouth feel dry? | Y N Are you aware of an uncomfortable bite? |
| Y N Do you feel pain when your teeth come in contact with: | Y N Have you had a blow to the jaw (trauma)? |
| ____ Hot foods or liquids | Y N Are you a habitual gum chewer? |
| ____ Cold foods or liquids | Y N Have you had orthodontics/braces? |
| ____ Sour foods | Y N Do you have your wisdom teeth? |
| ____ Sweets | |

Medical History

Do you have or have you had any of the following? (Please check any that apply)

- | | |
|---|---|
| <input type="checkbox"/> Being treated for a medical condition
Please explain: _____ | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Have/had any serious illness or operation? _____

_____ | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Smoke or use chewing tobacco
_____frequency | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Recreational drug use: _____
_____frequency | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Artificial Joints
Type and When: _____ | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleep apnea
CPAP? Y/N |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sinus Problems |
| | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Thyroid condition |
| | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Tumors |
| | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Venereal Disease |
| | Other: _____ |

Name: _____

(Medical History Continued)

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin/Acetaminophen/Ibuprofen
- Metals
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers

Please list: _____

- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine

Please list: _____

- Antibiotics prior to dental appointments?
- Other: _____

Women:

- May be pregnant
Expected delivery date: _____
- Nursing
- Taking hormones or contraceptives

Name of your physician: _____ Date of last visit: _____

Do you have any disease, condition, or problem not listed above? _____

Please list all medications (including supplements): _____

Please add anything else you would like us to know about: _____

I have read the above questions and understand them. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist of any changes in my medical or dental health.

Signature of patient (or parent): _____ Date: _____



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Dental Insurance and Financial Arrangements

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

If you have dental insurance we will work hard to help you receive your maximum allowable benefit. In order to achieve this goal we need you to take the necessary steps to understanding your insurance plan. Being there are so many different providers and plans, it is impossible for us to know all of our patients' benefits. It is very important for you as a dental insurance policy holder, to be aware of the plan benefits, deductibles, and exclusions. Plan benefits can be obtained by calling your dental insurance company. We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You, however, must be aware that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a yearly deductible that is your responsibility to pay.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you will be responsible for the remainder.
4. Not all services are a covered benefit in all contracts. It is important for you to contact your insurance provider and ask if there are any clauses, or waiting periods.
5. As a courtesy to you, our office will submit claims to your insurance provider. If for any reason the claims go unpaid you will be responsible for all charges.

If you have any questions regarding this information, or any uncertainty regarding insurance coverage please don't hesitate to ask us, we are here to help you in any way we can.

I _____ am financially responsible for any and all charges on my account.

I have read and understand the above information.

Signature of patient (or parent): _____ Date: _____

I authorize release of any information regarding my dental treatment to my dental and/or medical insurance company.

Signature of patient (or parent): _____ Date: _____



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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of Mill Creek Dental’s Notice of Privacy Practices. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

- No one
- Any immediate family member
- Spouse only
- Other (Please Specify): _____

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____



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**Authorization and Consent to Send Unencrypted Patient Information
by Email and Other Electronic Means**

Until I tell you in writing to stop, I authorize Mill Creek Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Mill Creek Dental's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Mill Creek Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Mill Creek Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Mill Creek Dental already sent before receiving my written instructions to stop.

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____

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Cancellation/Missed Appointment Policy

We recognize there are times when an appointment is scheduled that you, the patient, has to cancel or postpone.

Our policy requires you to give a 48 business hour notice for any re-scheduled or cancelled appointments.

If less than a 48 business hour notice is given there will be a \$50 late cancellation fee added to your account. Any appointments missed with no notice will have a \$101 missed appointment fee added to your account.

We understand that occasionally a circumstance may arise which can cause missed appointments, but it does leave a void in our schedule that may have been used by another patient. We do not like to do this, however, in order to keep your patient fees lower we need to ensure all patients keep their scheduled appointments.

By signing below you have acknowledged and understand this policy.

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____