Menlo Park Dental Excellence/ChauLong T. Nguyen Dental Corporation

ChauLong Nguyen, DDS, MAGD, LLSR, AF AAID

905 Middlefield Road, Ste B, Palo Alto, CA 94301 (650) 838-0260

PATIENT INFORMATION

Name: _____ **Home Phone: _____**

Address: _____ **Office Phone: _____**

City: _____ **Cell Phone: _____**

State & Zip: _____ **E-mail address: _____**

Date of Birth: _____ **Marital Status: _____**

Gender: _____ **Social Security: _____**

The law requires that all prescriptions in California shall be issued as an electronic data transmission prescription (e-prescriptions).

Pharmacy Name: _____

Address: _____ **Phone #: _____**

Person responsible for account: ▢ Self or ▢ Other:_____

IF PATIENT IS A CHILD/MINOR
Name of Parent or Guardian: _____
Phone #: _____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

Primary Insurance	*Secondary Insurance*
Name of Insured: _____	**Name of Insured: _____**
Employer: _____	**Employer: _____**
Social Security #: _____	**Social Security #: _____**
Date of Birth: _____	**Date of Birth: _____**
Insurance Co. Name: _____	**Insurance Co. Name: _____**
Member ID:_____	**Member ID: _____**
Group or Plan #: _____	**Group or Plan#: _____**
Signature: _____	**Date: _____**

Menlo Park Dental Excellence/ChauLong T. Nguyen Dental Corporation

FINANCIAL POLICY

NOTE: We Accept All PPO insurances. ***We are in network with Delta Dental Premier PPO only.***
All other out-of-network PPO insurance plans will require a co-payment at the time of service.

Patients WITH Dental Insurance

- Patients should understand that services are rendered and charged to you and not to the dental insurance company. We are happy to send claims to your insurance company for you; however, we suggest that you call your dental insurance company to confirm your eligibility, what services are covered and at what percentage that they will be covered for and how much your calendar or fiscal yearly maximum is.

For X-Rays, routine examination and cleaning appointments we request ful payment at time of provided care.

Emergency Detailed Tooth Pain Focus Exam cost $350 for Delta Premier & out of network insurances.
Delta Dental Premier patients are required to pay $245 for numbing inflamed bleeding painful gum.

- It is your responsibility to provide us with your correct insurance billing information if you choose to have us bill claims to your insurance company for you. This information includes your insurance company's name, address and contact information, the subscriber's employer if covered through a workplace policy, the identification number, and policy or group number that the insurance carrier uses to identify you. If we cannot verify your eligibility, then you will be responsible for the full cost of the services at the time they are rendered. Provide and update with us if your insurance has Calendar or Fiscal effective coverage dates.
- We are happy to provide you with a proposed treatment plan with estimated fees.
- Proposed treatment plans can be pre-authorized by your insurance company for you to determine your co-payment. These pre-authorizations take approximately 15 business days to be completed. Please be aware that the proposed plan may change at the time of treatment. You are required to pay the predetermined co-payment amount at the time of treatment.
- If you choose to go ahead with treatment before the pre-authorization is completed and received, you may be required to pay the amount of the treatment in full at the time the services are rendered. We will be happy to provide you with a claim that you may then submit to your insurance company and they can reimburse you directly for the costs of treatment.

Patients WITHOUT Dental Insurance

Payment in full is required at the time services are rendered. If you decide you cannot afford the treatment plan that is proposed, we are happy to refer you to Dental Schools/ other providers for your dental care. We will send all the necessary documentation and x-rays to your email so that you can forward your records to your future dentists.

We accept cash, checks - with a valid ID, major credit and debit cards.

Appointment time is reserved specifically for you. Please give us a minimum of 24-hour notice for cancellations or rescheduling. Less than 24-hour notice may result in a $50.00 cancellation charge.

By signing, you acknowledge and accept our financial policy as well as understanding your financial responsibility towards your dental care services.

Signature: _____ **Date**: _____

Menlo Park Dental Excellence
905 Middlefied Road. STE B. Palo Alto.CA 94301
650-838-0260 MpDentalExcellence.co

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
   Primary Care Physician Name: _____ Phone Number: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, where and explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint: Type/ Date of surgery: _____		Yes / No Hepatitis
Yes / No Loss of hearing; full or partial	Yes / No Family history of diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Tumors or cancer	Yes / No Diabetes
Yes / No Heart defects	Yes / No Sexually transmitted diseases	Yes / No Herpes
Yes / No Pacemaker: Date implanted: _____		Yes / No Heart murmur
Yes / No Chemotherapy	Yes / No Rheumatic fever	Yes / No Radiation
Yes / No Canker or cold sores	Yes / No Skin disease	Yes / No Arthritis, rheumatism
Yes / No Anemia	Yes / No Hardening of arteries	Yes / No Liver disease
Yes / No Emphysema or other lung disease	Yes / No High blood pressure	Yes / No Eye disease

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Yes / No	Kidney or bladder disease	Yes / No	Seizures	Yes / No	Stroke
Yes / No	Transplants	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Tuberculosis	Yes / No	General Anesthesia	Yes / No	Conscious Sedation
Yes / No	Deep Sedation	Yes / No	Moderate Sedation	Yes / No	Mild/Minimal Sedation

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or sedatives	Yes / No	Codeine or other opioids
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal
Yes / No	General Anesthesia	Yes / No	Sedation Anesthesia	Yes / No	Conscious Sedation

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Antidepressants	Yes / No	Herbal supplements		

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan, Tramadol) If YES, please explain reason:

_____

Please list all prescription medications taken within the last 14 days: _____

_____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have, or have you hod any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you tested positive for COVID-19?
If YES, dote of positive test result: _____

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result of exposure to Covid-19?
If YES, what are these symptoms or effects? _____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?
If YES, please list _____

If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

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I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Menlo-Park-Dental-Excellence-DENTAL HISTORY

Baseline Examination

Date of your last visit to a dentist: _____

Reason for your last visit (or series of visits): _____

Do you have any x-rays and/or photos of your dental records? ☐ Yes ☐ No ☐ Not Sure

Approximately when were these x-rays and/or photos taken? _____

In respect to any previous dental treatment, have you…? (Please check one answer)

1) Ever fainted? ☐ Yes ☐ No ☐ Not Sure
2) Had an allergic reaction? ☐ Yes ☐ No ☐ Not Sure
3) Had abnormal bleeding? ☐ Yes ☐ No ☐ Not Sure
4) Had any other complications during or following dental treatment? ☐ Yes ☐ No ☐ Not Sure
   If yes, please describe: _____
5) Do your gums bleed when brushing, flossing or eating? ☐ Yes ☐ No ☐ Not Sure
6) Does food catch between your teeth? ☐ Yes ☐ No ☐ Not Sure
7) Have your teeth shifted, or are there spaces between your teeth now where there were none, or are your teeth flaring, or are some of your teeth becoming loose? ☐ Yes ☐ No ☐ Not Sure
8) Are any of your teeth sensitive to heat, cold and/or pressure? ☐ Yes ☐ No ☐ Not Sure
9) Do you grind your teeth or clench your jaws? ☐ Yes ☐ No ☐ Not Sure
10) Do you have pain or clicking in the jaw joint around your ear? ☐ Yes ☐ No ☐ Not Sure
11) Have your jaw muscles ever sore? ☐ Yes ☐ No ☐ Not Sure
    If yes, please describe: _____
12) Are there any sores or growths in your mouth? ☐ Yes ☐ No ☐ Not Sure
13) Do any of your teeth ache? ☐ Yes ☐ No ☐ Not Sure
14) Do you have any problems chewing gum or bagels? ☐ Yes ☐ No ☐ Not Sure
15) Have your teeth changed within the last five years? ☐ Yes ☐ No ☐ Not Sure
16) Do you have trouble sleeping? ☐ Yes ☐ No ☐ Not Sure
17) Do you notice your teeth grinding, clenching or worn? ☐ Yes ☐ No ☐ Not Sure
18) Do you have any other dental concerns? _____

Appliances

1) Do you have any fixed non removable bridges in your teeth? ☐ Yes ☐ No ☐ Not Sure
   ☐ Upper or ☐ Lower ☐ Left or ☐ Right
2) Do you have any removable dentures? ☐ Yes ☐ No ☐ Not Sure
3) Do you have any retainer for Invisalign or regular braces? ☐ Yes ☐ No ☐ Not Sure
4) Do you have any splints, stents, sport mouth guard, hard or soft night guard? ☐ Yes ☐ No ☐ Not Sure

Please note that any change in your health status should be reported to our office at the earliest possible time.
To the best of my knowledge, the above-mentioned questions have been accurately answered.

Signature: _____ Date: _____

ChauLong T Nguyen Dental Corporation/Menlo Park Dental Excellence
ChauLong T Nguyen, DDS, MAGD, LLSR, AFAAID
905 Middlefield Rd, STE B, Palo Alto, CA 94301
Office #: (650) 838-0260 Email: chaulongdds@protonmail.com

Patient Photograph Authorization Form

CONSENT TO THE USE OF THESE IMAGES (please circle "yes" or "no")

1) Do you give consent for ChauLong Nguyen Dental Corporation to take photographs, slides, and/or videotape of your jaw and teeth? YES NO

2) Do you understand that these images will become part of the patient record? YES NO

3) Do you understand that these images will become part of the patient's dental insurance record? YES NO

4) Do you understand that some of these images may be used for laboratories for fabrication of crowns, veneers bridges or dentures? YES NO

5) Do you consent to the use of these images in professional articles and presentations? YES NO

6) Do you consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice and lab? YES NO

7) Do you consent to the use of these images to promote the dental practice through various media, including but not limited to advertising, brochures and the practice website, Yelp, Google and Facebook? YES NO

By consenting to the use of these images and/or photographs as described above, I do not expect compensation, financial or otherwise from ChauLong Nguyen Dental Corporation (Menlo Park Dental Excellence). I hereby release and discharge ChauLong Nguyen Dental Corporation (Menlo Park Dental Excellence) from all claims and demands arising out of or in connection with the use of my name, photograph, or other information provided by me, including all claims for libel and invasion of privacy.

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. Unless revoked by me in a written form, this authorization expires 10 years from the date I sign below. I understand that I may have a copy of this authorization.

_____ _____

Patient's (or Representative's) Signature **Date**

ChauLong T Nguyen Dental Corporation
Menlo Park Dental Excellence
ChauLong T Nguyen, DDS, MAGD, LLSR, AFAAID
881 Fremont Ave, Ste A4 Los Altos, CA 94024
Office #: (650) 838-0260 Email: chaulongdds@protonmail.com

Consent for Use and Disclosures of Health Information

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 activities, and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practice 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 the important matter about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it completely before signing this Consent.

We reserve the right to change our privacy policies 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 changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to ChauLong T. Nguyen, DDS. Please understand that the 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.

I acknowledge that I have received from Menlo Park Dental Excellence a copy of the Dental Board of California's *"The Facts About Fillings*."

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 my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____

Patient's (Patient Representative) Signature **Date**

Menlo Park Dental Excellence

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 05/01/21, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $32 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation on how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. **{Your request must be in writing, and it must explain why the information should be amended.}** We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: ChauLong Nguyen, DDS

Telephone: (650) 838-0260 **Fax**: (818) 928-6058

Email: chaulongdds@protonmail.com

Address: 881 Fremont Ave, Ste A4
Los Altos, CA 94024

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