Dental Patient Survey

Please assist us in making your in-office experience a memorable one…

Please indicate your language of preference:

☐ English ☐ Spanish ☐ Chinese Other _____

1. Where did you find us:

- ☐ Our website
- ☐ Yelp
- ☐ Zocdoc
- ☐ Google
- ☐ Friend/Family:_____
- ☐ Walking/Passing by
- ☐ Brochure
- ☐ Other : _____

2. What would you most want to achieve from dental care?

3. How would you describe the perfect Dentist? Be Specific.

4. What key factors most influence you when choosing a Dentist?

Patient Health History

Patient's Name:_____

First Middle Last

D.O.B: _____ Age:_____ SS#:_____ Sex: ◉ M ○ F

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #: _____ Work Phone #:_____ Cell# :_____

Email:_____ Marital Status:_____

Employer:_____ Occupation: _____

Employer Address:_____

Spouse's (Parent/Guardian, *if child*) Name:_____ D.O.B.: _____

Employer:_____ Occupation:_____

Dental Insurance Information

(1) Primary Insurance Carrier: _____ Telephone #:_____

Group #:_____ Plan#:_____ Does patient have additional coverage? ○ Yes ○ No

Insured's Name:_____ D.O.B.:_____ Social Security #: _____

Employer Name & Address: _____

(2) Secondary Insurance Carrier:_____ Telephone #:_____

Group #:_____ Plan#:_____

Insured's Name:_____ D.O.B.:_____ Social Security #: _____

Employer Name & Address: _____

In case of Emergency, Contact: _____ Relationship to Patient:_____

Home #: _____ Work #: _____ Cell #:_____

Dental History

Reason for today's visit:_____ Date of last dental visit:_____

_____

Signature of Patient or Parent/Guardian

Health History

Physicians Name:_____ Date of last visit:_____

Physicians Phone #:_____

Have you ever taken any of the group of medications collectively called "fen-phen?" ☐ Yes ☐ No

Have you had Biphosphonate Theraphy? ☐ Yes (If you have taken Aredia or Zometa) ☐ No

For how long? _____

Please indicate if you have had any of the following:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☉	Abnormal Bleeding	☐	☐	Heart Attack/Surgery	☐	☐	Ulcers
☉	☐	Allergies	☐	☐	Heart Murmur	☐	☐	Venereal Disease
☐	☐	Anemia	☐	☐	Hemophilia	☐	☐	Yellow Jaundice
☐	☐	Angina Pectoris	☐	☐	Hepatitis A	☐	☐	Alcohol Abuse
☐	☐	Arthritis	☐	☐	Hepatitis B	☐	☐	Bruise Easily
☐	☐	Artificial Bones	☐	☐	High Blood Pressure	☐	☐	Anesthetic Sensitivity
☐	☐	Artificial Heart Valve	☐	☐	Kidney Problems	☐	☐	Obesity
☐	☐	Asthma	☐	☐	Liver Disease			
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure	☐	☐	Do you smoke
☐	☐	Cancer-Chemotherapy	☐	☐	Mitral Valve Pressure			or use tobacco?
☐	☐	Congenital Heart Defect	☐	☐	Pace Maker			
☐	☐	Diabetes	☐	☐	Pneumocystitis	Weight _____ Height _____		
☐	☐	Difficulty Breathing	☐	☐	Psyciatric Problems			
☐	☐	Drug Abuse	☐	☐	Radiation Therapy	If female, please answer the following:		
☐	☐	Emphysema	☐	☐	Rheumatic Fever			
☐	☐	Epilepsy	☐	☐	Seizures	☐	☐	Are you pregnant?
☐	☐	Fainting Spells	☐	☐	Shingles	If yes, # of weeks: _____		
☐	☐	Fever Blisters	☐	☐	Sickle Cell disease			
☐	☐	Frequent Headaches	☐	☐	Sinus Problems	☐	☐	Are you nursing?
☐	☐	Glaucoma	☐	☐	Stroke	☐	☐	Are you taking
☐	☐	HIV/AIDS	☐	☐	Thyroid Problems			Birth Control Pills?
☐	☐	Hay Fever	☐	☐	Tuberculosis			

Allergies

Yes	No	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other: _____

Is there any disease and/or condition not listed that we should know about? ☐ Yes ☐ No

If yes, please indicate below:

_____

_____

Please list any medications that you are presently taking:

_____

_____

_____

_____ _____ _____

Signature of Patient or Parent/Guardian | Print Name | Date

For Office Use Only	BP	Heart Rate

_____ _____

Dentist's Signature | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement**

In accordance with federal law, I _____(Patient Name), have received a copy of this office's Notice of Privacy Practices.

Do you give us permission to confirm appointments by phone, message, and by mail? ◯ Yes ◯ No

Do you give us permission to discuss your treatment, insurance coverage, and treatment plan with a family member?
◯ Yes ◯ No

If so, please list the names of those you authorize our office to discuss this information with:

_____

_____ _____

Patient/Responsible Party's Signature Date

For Office Use Only

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

☐ Individual Refused to Sign ☐ Communication Barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify): _____

_____

Patient Dental Treatment Consent Form

Examination, X-Rays, Photos & Diagnosis

☐ I understand that dental x-rays (radiographs) and photos are a necessary part of the diagnosis process and consent to having any dental x-rays (radiographs) necessary. I understand that the examination and diagnosis process involves x-rays (radiographs), oral cancer screening, and perio chart probing and I consent to this process. I understand that should treatment be diagnosed for me that I will be given the opportunity to ask any questions. Also, any fees associated with any treatment will be discussed with me at that time.

Initials _____

Oral Hygiene and Periodontics

☐ I understand that the long term success of treatment and status of my oral condition depends strongly on my efforts to maintain proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits as recommended by Dr. Wang.

Initials _____

☐ I understand that I have a serious condition, causing gum and bon inflammation and/or loss, that if it can lead to the loss of my teeth and many other complications. The various treatment plan options have been explained to me, including gum therapy and/or surgery, and replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extractions.

Initials _____

Changes in Treatment Plan

☐ I understand that during treatment it may be necessary to change and or add treatment procedures due to 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 Dr. Wang to make any/all changes to my treatment plan as necessary.

Initials _____

Drugs, Medications, and Anesthesia

☐ I understand that antibiotics, analgesics, and other medications may cause diverse reactions, some of which are, but are not limited to; redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, and cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol and/or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous devise while taking medication and/or drugs until fully recovered from their effects. I understand that occasionally upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection.

Initials _____

☐ I understand that if I select to utilize Nitrous Oxide, “Atarax”, Chloral Hydrate, “Zanax”, or any other sedative possible risks includes, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation and that someone needs to watch me closely for a period of 6 to 8 hours thereafter.

Initials _____

Fillings – Restorations

☐ I have been advised of the need for fillings, Composite Resin (Tooth Colored), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to the wear of the material. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate fee.

Initials _____

Endodontic Treatment (Root Canal Therapy)

☐ I realize that there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (i.e. extractions and apicoectomy).

Initials _____

☐ Alternatives to the removal of teeth if any have been explained to me including, root canal therapy, crowns, and or periodontal surgery, and I authorize Dr. Wang to remove the following teeth _____ and any others necessary due to the possibility of treatment plan changes as outlined above. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue, and surrounding tissue which may last for an indefinite period of time (days or months). I understand that should I need further treatment by a specialist or even hospitalization, if complications should arise, the cost of such is my responsibility.

Initials _____

Crowns (Caps) and Bridges

☐ I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that at times during the preparation of a tooth for a crown or bridge, pulp exposure may occur, necessitating root canal therapy. I understand that natural teeth, crowns, and bridges need to be kept clean, by maintaining proper regular and oral hygiene and periodic cleanings and exams. Otherwise, decay (cavity) may develop underneath and/or around the margins of the restoration, leading to the need for further dental treatment.

Initials _____

Dentures, Complete or Partial

☐ I realize that full or partial dentures are artificial, constructed of acrylic, metal and/or porcelain. The problems or wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. I understand that any adjustments done within 3 months of the delivery of the appliance are included in the original treatment fee, and that any adjustments beyond that will be at $75.00 per visit, per appliance. In addition, I understand that most dentures and partials require relining approximately three to six months after initial placement. The cost for this procedure is not included in the initial treatment fee.

Initials _____

General Consent

☐ I understand that any insurance benefits quoted are not a guarantee of benefits but, rather an estimate based on the information provided to our office by your insurance carrier. I understand that I will be financially responsible for any amount(s) not covered by my insurance carrier. I understand that it is the patient's responsibility to know and understand their individual insurance benefits and that this office has verified my insurance benefits as a courtesy to me.

Initials _____ **(only for dental insured patient)**

☐ I understand that should I fail to make payment on my account that a $15.00 per month late charge will be applied. In addition I understand that I will be responsible for a $25.00 returned check fee for any and all returned checks. Also, should my account be referred to collections, I understand that I am responsible for a $50.00 Administrative Collection Fee in addition to any outstanding balance.

Initials _____

☐ I understand that this facility provides dental care services without discrimination based on race, religion, color, nationality, sex, sexual orientation, physical or mental disability, age and/or, and protect the privacy of each of its individual patients.

Initials _____

☐ I certify that I have had the opportunity to read and fully understand the terms and conditions outlined within this document, and consent to cooperation and/or explanation referred to or made. I have been encouraged to ask questions, and have had them answered to my satisfaction.

Initials _____

_____ _____

Print Patient's Name Date

_____ _____

Responsible Party's Signature Relationship to Patient

FOR OFFICE USE ONLY

_____ _____

Doctor's Signature Date

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____(Patient Name), acknowledge receipt of

a copy of the Dental Materials Fact Sheet from Link Dental Center

as mandated by the Dental Board of California as of October 2001.

_____ _____

Patient's / Responsible Party's Signature Date

CANCELLATION POLICY

AN APPOINTMENT TIME AND ROOM HAS BEEN RESERVED FOR YOU. PLEASE NOTIFY THE OFFICE WITHIN 48 HOURS FOR CANCELLATION OR NEED TO RESCHEDULE. A $50.00 FEE WILL BE INCURRED FOR A WEEKDAY BROKEN APPOINTMENT. A $100 FEE WILL BE INCURRED FOR A WEEKEND BROKEN APPOINTMENT.

OUR VOICEMAIL IS AVAILABLE 24 HOURS A DAY DURING WEEKENDS. YOUR HEALTH PLAN DOES NOT COVER FOR MISSED APPOINTMENTS.

_____ _____

PATIENT SIGNATURE DATE

Submit