TRANG T. CHESLER, DDS
374 N. EL CAMINO REAL | ENCINITAS, CA 92024
760.942.3745 OFFICE | 760.942.7801 FAX

## Personal Information

Today's date_____

First name_____ Middle initial_____ Last name_____

I prefer to be called _____ ☐ Male ☐ Female

Address_____City_____State_____ ZIP_____

Date of Birth_____ Social Security #_____

Cell Phone _____ Work Phone_____ Home Phone_____

Primary contact number (Check one) ☐ Cell ☐ Work ☐ Home

Email_____ Employer_____

Spouse's name_____ Spouse's employer_____

Whom may we thank for referring you?_____

Are you currently a student? School_____Grade/Year_____

Emergency contact person/ contact number_____

## Dental Information

Reason for today's visit_____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe_____

Do you have any dental problems right now? ☐ Yes ☐ No

If so, please describe_____

Have you ever had trouble with previous dental treatment? ☐ Yes ☐ No

If so, please describe_____

Anything we can do to improve upon your past dental treatments? _____

Please rate your level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

TRANG T. CHESLER, DDS
374 N. EL CAMINO REAL | ENCINITAS, CA 92024
760.942.3745 OFFICE | 760.942.7801 FAX

Approximate Date of last cleaning _____

Procedure(s) done at last dental visit _____

Are you looking for a change in the way your smile looks? ☐ Yes ☐ No

**If you could change anything about your teeth, it would be (Check all that apply)**

☐ Color of your teeth
☐ Too much or too little of teeth show when you smile
☐ Size/Shape of your teeth
☐ Too much or too little gum shows when you smile
☐ Gaps between your teeth
☐ Alignment of your teeth
☐ Other _____

**Do you have? (Check all that apply)**

☐ Sensitive or receding gums
☐ Worn/broken/chipped teeth
☐ Missing teeth
☐ Old crowns that have dark edges at the top
☐ Teeth sensitive to heat/cold
☐ Teeth sensitive while chewing
☐ Concerns about bad breath
☐ Old or discolored fillings
☐ Other _____

**Have you ever experienced? (Check all that apply)**

| | | | |
|---|---|---|---|
| Periodontal disease/gum treatment | ☐ Yes ☐ No | Discomfort in you jaw point (TMJ/TMD) | ☐ Yes ☐ No |
| Orthodontics treatment | ☐ Yes ☐ No | Your bite adjusted or balanced | ☐ Yes ☐ No |
| Oral surgery/ Wisdom Teeth | ☐ Yes ☐ No | Serious injury to the mouth or head | ☐ Yes ☐ No |
| A bite plate or mouth guard | ☐ Yes ☐ No | Chronic bad breath | ☐ Yes ☐ No |
| Snoring | ☐ Yes ☐ No | Grinding of teeth (day or night) | ☐ Yes ☐ No |

If yes to any of the previous questions, please describe _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No If yes, why? _____

_____

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Bisphosphonates) ☐ Yes ☐ No

Is there anything else about your past dental treatment(s) that you would like us to know

_____

TRANG T. CHESLER, DDS
374 N. EL CAMINO REAL | ENCINITAS, CA 92024
760.942.3745 OFFICE | 760.942.7801 FAX

# Medical History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No
Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

**Women: Are you**

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

**Are you allergic to any of the following?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

**Do you have, or have you had, any of the following?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur Heart ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Pacemaker Heart ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

TRANG T. CHESLER, DDS
374 N. EL CAMINO REAL | ENCINITAS, CA 92024
760.942.3745 OFFICE | 760.942.7801 FAX

## Dental Insurance

**Primary Carrier:**

Insurance co. name_____ Insured's I.D. no._____

Insured's name_____ Relationship to patient_____

Date of birth of Insured _____ Insured's employer name _____

**Secondary Carrier:**

Insurance co. name_____ Insured's I.D. no._____

Insured's name_____ Relationship to patient_____

Insured's date of birth_____ Insured's employer name_____

**If the patient is a minor**:

Name of parent or legal guardian and relationship_____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

## HIPPA Privacy

**Acknowledgement of Receipt of Privacy Practices**

Purpose: The purpose of this form us used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I,_____,have received a copy /explanation of this office's Notice of Privacy Practices.

_____ _____ _____

Signature of Patient or Guardian | Relationship to Patient | Date

For Office Use Only

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

- □ Individual refused to sign
- □ Communication barriers (such as language barrier) prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement at the time of service
- □ Other (Please specify)_____

## Office and Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of $50 per hour may be posted to your account if an appointment is cancelled without a 48 hour advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per annum. A returned check fee of $25 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Trang T. Chesler, DDS.

**I have read and understand this financial policy.**

PRINTED NAME SIGNATURE DATE

TRANG T. CHESLER, DDS
374 N. EL CAMINO REAL | ENCINITAS, CA 92024
760.942.3745 OFFICE | 760.942.7801 FAX

## Photography Release

I _____, hereby authorize Dr. Trang T. Chesler to take photographs and or videos of my face, jaws, and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

Signature Date

# Acknowledgement of Receipt of Notice of Privacy Practices

**You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)