



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 (1 is least and 5 is most)



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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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discomfort in you jaw point (TMJ/TMD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthodontics treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Your bite adjusted or balanced | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Oral surgery/ Wisdom Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serious injury to the mouth or head | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A bite plate or mouth guard | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Snoring | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding of teeth (day or night) | <input type="checkbox"/> Yes <input type="checkbox"/> 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



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



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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 is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

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



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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

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- Communications barriers prohibited obtaining the acknowledgement
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- Other (Please Specify)