A. Jayson Tengonciang,D.M.D.

PATIENT INFORMATION

(PLEASE PRINT)

Nickname _____

NAME *(CIRCLE):* **MR. MRS. Mrs. DR.**_____ **BIRTHDATE**_____
FIRST MIDDLE INT. LAST

ADDRESS_____
STREET CITY STATE ZIP

PREFERRED PHONE NO._____**OTHER #** (*type*)_____

EMPLOYER OR SCHOOL_____ **SSN**._____

IS THE PATIENT A FULL TIME STUDENT? _____ **EMAIL ADDRESS**: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

WHAT MUSIC PREFERENCE WOULD YOU LIKE TO LISTEN TO DURING YOUR TREATMENT:_____

Is the financial responsible party the patient? NO YES

IF NO, PLEASE COMPLETE THE FOLLOWING FOR WHO IS RESPONSIBLE FOR PAYMENT

NAME _____ _____
FIRST MIDDLE LAST RELATIONSHIP TO PATIENT

ADDRESS_____
STREET CITY STATE ZIP

PHONE _____

SOCIAL SECURITY No. BIRTH DATE DRIVER'S LICENSE NO. _____

EMPLOYER_____

DENTAL BENEFIT INFORMATION

****** DO YOU HAVE ACTIVE DENTAL COVERAGE?*** **NO YES**

IF YES, PLEASE COMPLETE THE FOLLOWING:

POLICY HOLDER'S NAME: _____

BIRTH DATE _____

SSN or Subscriber ID of Policy Holder_____**RELATIONSHIP TO PATIENT:** _____

CARRIER'S NAME: _____

POLICY HOLDER'S EMPLOYER:_____**GROUP NO. GROUP NAME**_____

****** DO YOU HAVE SECONDARY DENTAL COVERAGE?*** **NO YES IF YES, PLEASE COMPLETE THE FOLLOWING:**

POLICY HOLDER'S NAME: _____ **BIRTHDATE**_____ **SSN.**_____

RELATIONSHIP TO PATIENT:_____

CARRIER'S NAME:_____

POLICY HOLDER'S EMPLOYER _____**GROUP NO.** _____ **GROUP NAME**_____

EMERGENCY CONTACT: NAME_____ **RELATIONSHIP**_____ **PHONE:**_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Signature: _____Date:_____

Confidential Health History

I. CIRCLE APPROPRIATE ANSWERS FOR EACH

1. Yes / No Are you in general good health?

If NO, explain: _____

2. Yes / No In the last 3 years, have you gone to the hospital, emergency room, or had a serious illness?

If YES, explain: _____

3. Yes / No Are you being treated by a physician now?

If YES, explain: _____

II. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL ISSUES? (CIRCLE Yes or No FOR EACH)

Yes/No TMJ	Yes/No Tuberculosis	Yes/No Heart Disease
Yes/No High Blood Pressure	Yes/No Fatigue	Yes/No Heart Murmur/Defect
Yes/No Respiratory/Asthma	Yes/No Swelling	Yes/No Pacemaker
Yes/No Rheumatic Fever	Yes/No Psychiatric Care	Yes/No Heart Attack/Stroke
Yes/No Gastric Bypass	Yes/No Ulcers/Digestive	Yes/No Irregular Heart Beat
Yes/No Immunocompromised	Yes/No Migraine/Headaches	Yes/No Prosthetic Implant
Yes/No Anemia	Yes/No Epilepsy/Migraine	Yes/No Any Transplant
Yes/No Diabetes Type_____	Yes/No Glaucoma/Visual	Yes/No Joint Replacement
Yes/No Herpes	Yes/No Mental/Neural	Yes/No Arthritis
Yes/No Hypoglycemia	Yes/No Tumor/Neoplasm	Yes/No Past Root Canals
Yes/No Smoke	Yes/No Alcoholism Addiction	Yes/No Thyroid Problems
Yes/No Shortness of Breath	Yes/No Infectious Diseases	Yes/No Language Interpreter needed
Yes/No Cancer	Yes/No HIV	
Yes/No Radiation/Chemo	Yes/No Hep B or C: (list)_____	Other:_____

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

(CIRCLE Yes or No FOR EACH)

Yes /No Aspirin	Yes / No Valium/Tranquil. (list below)	Yes / No NSAID
Yes /No Antibiotics (list below)	Yes / No Latex	Yes / No Local Anesthetics (list below)
Yes /No Tylenol	Yes / No Narcotics (list below)	Yes / No Sulfa

OTHER KNOWN ALLERGIES: _____

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS?

(CIRCLE Yes or No FOR EACH)

Yes / No Antidepressants	Yes / No Blood Thinners	Yes / No Antibiotics
Yes / No Bisphosphonate(Fosamax)	Yes / No Osteoporosis Medication	Yes / No Insulin

LIST ALL MEDICATIONS:_____

V. WOMEN ONLY (CIRCLE Yes or No FOR EACH)

Yes / No Are you or could you be pregnant? If YES, expected due date?_____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VI. ALL PATIENTS (CIRCLE Yes or No FOR EACH)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please, explain: _____

Yes / No Have you ever been premedicated for dental treatment? If YES, why:

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

Your General Physician's Name: _____

If A. Jayson Tengonciang, DMD INC determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize A. Jayson Tengonciang, DMD INC. to contact my physician. 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 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_____

A. Jayson Tengonciang,D.M.D.
FINANCIAL POLICY

We are committed to providing you with the highest level of care and building a successful provider- patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them.

Protecting your identity starts with taking easy steps to protect yourself, like asking what will be done with your personal information in the doctor's office. It is office policy that a patient will not be seen without a copy of a valid photo ID on file to confirm your identity and to prevent insurance fraud. We also require documentation of your social security number when insurance is involved. However, giving your social security number is not legally required. If you prefer not to provide us with your social security number and still would like us to bill your benefit carrier, you will have to pay the doctor's fee (in full) the day of your appointment and we will happily reimburse you when your plan pays their estimated portion; this is office policy. The reason we require your social security number is to ensure payment when claims are billed. We truly understand the fears you may have about releasing this important information to us, but please know security is a top priority at our office, and we do everything HIPAA requires of us to stay compliant and to abide by their laws. Please do not hesitate to ask us the ways we keep your information safe; it would be our pleasure to discuss this with you.

PAYMENTS

Payment for services will be due in full at the time of service

We make payment as convenient as possible by accepting cash, money order, MasterCard, Visa, Discover and in-state checks. A $35.00 service fee will be charged for all returned checks. If you require financial assistance, we have assistance through CareCredit; our office will not do any type of personal financing. Additionally, by signing below, you authorize our office to accept any over the phone payments, knowing that we adhere to the highest level of information security. Also, by signing below you give consent to our office to call your cell phone to discuss your account and insurance information.

DENTAL BENEFITS

Copayments and/or deductibles are due in full the day of service

As a courtesy to our patients, we will file your PPO claims for you. Please understand that your plan is an agreement between you and your carrier. Our office has no say in how claims are paid. We will do our best to give you an ESTIMATE on what we expect from your plan, but ultimately your benefit carrier makes that decision.

It is your responsibility to know what type of coverage you have and any limitations there may be. There are many different policies and coverage amounts. We will do our best to find out what type of coverage you have, but please understand that any time we call to verify benefits we are told that anything they tell us is "not a guarantee of coverage" or even what they tell us "may or may not apply to your policy".

If after 45 days of the benefit plan not paying your assigned claim, the bill becomes the patient's responsibility; there are no exceptions. All patient balances that are not paid within 60 days of the first dated statement will be assessed a finance fee of $50. All balances unpaid after 90 days will be sent to our collection department.

Miscellaneous Information

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries. We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, or a$100missed appointment fee may apply.

I authorize the provider to release any information necessary to adjudicate my benefit claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the benefit carrier and/or the insurance commissioner for any reason on my behalf. In addition, I agree to assign benefits to Dr. Tengonciang for plan coverage. I agree to the amount owed, and that I also will be responsible for the fee charged by the collection agency for costs of collections, attorneys, and/or court costs if such action becomes necessary. I have read, understand and agree to the above financial policy.

Signature: _____ Date: _____

A. Jayson Tengonciang,D.M.D.

PRIVACY POLICY

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement and Consent

I acknowledge that I have today received a copy of the Notice of Privacy Practices. I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above. In addition, you can text our landline 24/7. Just like phone calls and voicemails, texting may not always be 100% secure depending on the mobile service you use. Knowing that, signing below indicates you authorize us to communicate with you via text. You can change the texting agreement at any time.

X_____ _____ _____

Print Patient Name (or Guardian) **Patient Signature** **Date**

I also give consent for information pertaining to my treatment, appointments, insurance benefits, and financial arrangements to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver):

Relationship: Date of Birth:

1_____

Relationship: Date of Birth:

2_____

Relationship: Date of Birth

3_____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____

Office Personnel (Signature) Office Personne (Print Name)

Date:_____

A. Jayson Tengonciang,D.M.D.

Informed Consent Cone Beam CT Scan

1. A CBCT scan, also known as Cone Beam Computerized Tomography , is an x-ray technique that produces 3D images of your skull that allows visualization of internal bony structures in cross section rather than as overlapping images typically produced by conventional x-ray exams. CBCT scans are primarily used to visualize bony structures, such as teeth and your jaw, not soft tissue such as your tongue or gums.

2. Advantages of a CBCT Scan over conventional x-rays:A conventional x-ray of your mouth limits your dentist to a two-dimensional or 2D visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional or 3D anatomy. CBCT examinations provide a wealth of 3D information which may be used when planning for interpretation of complex roots, root canal anatomy, and advanced dental restorative procedures. Benefits of CBCT scans include: A. Higher accuracy when planning implant placement surgery; B. Greater chance for diagnosing conditions such as vertical root fractures that can be missed on conventional x-ray films; C. Greater chance of providing images and information which may result in the patient avoiding unnecessary dental treatment; D. Better diagnosis of third molar (wisdom teeth) positioning in proximity to vital structures such as nerves and blood vessels prior to removal; E. The CBCT scan enhances your dentist's ability to see what needs to be done before treatment is started.

3. Radiation: CBCT scans, like conventional x-rays, expose you to radiation. In the office of Dr. A. Jayson Tengonciang, the dose of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is equivalent to 2 regular dental x-rays. However, all radiation exposure is linked with a slightly higher risk of developing cancer. But the advantages of the CBCT scan outweigh this disadvantage

4. Pregnancy: Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell the dentist if you are pregnant or planning to become pregnant.

5. Diagnosis of non-dental conditions: While parts of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist may not be qualified to diagnose conditions that may be present in those areas. If any abnormalities, asymmetries, or common pathologic conditions are noted upon the CBCT scan, it may become necessary to send the scan to an Oral and Maxillofacial Radiologist for further diagnosis. However, by signing this form, you are acknowledging that your dentist may not be qualified to diagnose all conditions that may be present, and that his/her liability only extends to the limits of the dental purpose of the scan and its interpretation for that purpose. We are not responsible for interpretation or evaluation of the scan, but are only providing the scan for the evaluation at your dental office.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE TO ACCEPT THE RISKS AND ADVANTAGES NOTED.

I, _____ being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have Dr. Alan Jayson Tengonciang and his staff as he may designate, perform a CBCT scan.

Signature of Patient, or Legal Guardian _____Date:_____

Witness to Signature_____Date:_____