Thuvan Vo, DMD
ViVi Spa Dental
10722 Ketchum Valley Drive
Riverview, FL 33579
Tel: 813-671-0675
Fax: 813-671-0695

Today's Date: _____/_____/_____

PATIENT INFORMATION: (CONFIDENTIAL)

Patient name: _____ Birth Date: _____/_____/_____
Address: _____

Home #: _____Work #:_____ Cell #: _____
SS#: _____
Patient employer: _____ Work Address: _____

PHARMACY PHONE NUMBER: (_____) _____-_____
PHARMACY NAME AND IN WHAT TOWN: _____

Person to call in an Emergency: _____
Phone#: _____
Whom may we thank for referring you: _____?

**********E-MAIL ADDRESS: _____***

RESPONSIBLE PARTY:

Person responsible for account: _____
Relationship: _____
Address: _____ Home #: _____
Drivers License #: _____ Employer: _____
Work Address: _____
Work #: _____ SS#:_____ Birthdate: _____/_____/_____

INSURANCE INFO:

Name of Insured: _____ Relationship to patient: _____
Birthdate: _____/_____/_____ SS#: _____ Ins. Co. _____
Group #: _____ Ins. Co. Address: _____
Ph # of Ins. Co.:_____ Insured Employer: _____
Employer Address: _____
Employers Ph #: _____

Do you Have Additional (Secondary) Insurance?_____YES NO_____

Name of Insured: _____ Relationship to patient: _____
Birthdate: _____/_____/_____ SS#: _____ Ins. Co. _____
Group #: _____ Ins. Co. Address: _____
Ph # of Ins. Co.:_____ Insured Employer: _____
Employer Address: _____
Employers Ph #: _____

	YES	NO
1. Are you having pain or discomfort at this time?		
2. Have you been a patient in the hospital during the past 2 years?		
3. Have you been under the care of a medical doctor during the past 2 years?		
3a. Physician's name & address:		
4. Have you taken any medication or drugs during the past 2 years?		
5. Are you taking any medication or drugs currently?		
5a. IF YES, PLEASE LIST:		
6. Are you sensitive or allergic to any medications or anesthetics?		
6a. IF YES, PLEASE LIST:		
7. When you walk up stairs, take a walk do you ever have pain in your chest, shortness of breath or become tired?		
8. Do your ankles ever swell?		
9. Do you use more than 2 pillows to sleep?		
10. Have you lost or gained more than 10 pounds in the past year?		
11. Do you ever wake up from sleep and feel short of breath?		
12. Are you on a special diet?		

Heart Failure	Y	N		Liver Disease	Y	N		Hemophilia	Y	N
Heart Disease/Attack	Y	N		Yellow Jaundice	Y	N		Blood Transfusion	Y	N
Angina Pectoris	Y	N		Hepatitis Type:	Y	N		Sickle Cell Anemia	Y	N
Congenital Heart	Y	N		COPD/Chronic Cough	Y	N		Artificial Joints	Y	N
Heart Murmur	Y	N		Tuberculosis	Y	N		Cold Sores/ Fever Blisters	Y	N
Arteriosclerosis	Y	N		Thyroid Disorder	Y	N		Epilepsy/Seizures	Y	N
Mitral Valve Prolapse	Y	N		Asthma	Y	N		Fainting/Dizzy Spells	Y	N
Heart Pacemaker	Y	N		Allergies/ Hives	Y	N		Glaucoma	Y	N
Heart Surgery	Y	N		Hay Fever	Y	N		Cortisone Medication	Y	N
Stroke	Y	N		Sinus Trouble	Y	N		Bruise Easily	Y	N
High Blood Pressure	Y	N		Cancer Type:	Y	N		Nervousness	Y	N
High Cholesterol	Y	N		Tumor	Y	N		Drug Addiction	Y	N
Arthritis	Y	N		Chemotherapy	Y	N		Developmentally Disabled	Y	N
Rheumatism	Y	N		Radiation Therapy	Y	N		Smoker?	Y	N
Rheumatic Fever	Y	N		A.I.D.S.	Y	N		How often: packs / day		
Kidney Trouble	Y	N		H.I.V Positive	Y	N		Coffee Drinker?	Y	N
Diabetes	Y	N		Venereal Disease	Y	N		How often: cups / day		
Do you have or have you ever had any disease, condition or problem not listed?										
FOR WOMEN: Are you pregnant: _____ If yes, what month:_____ Are you nursing_____ Type of Birth Control:_____										

CONSENT:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients' dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with **(name of patient)_____.** I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time of service as rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge (18% APR) may be added to my account.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum of a 48 hour notice so that we may accommodate another patient. A 15% charge of the scheduled procedure fee will be applied for broken and missed appointments without advance notification. We do however, understand emergencies do occur.
7. I understand that it is my responsibility to advise your office of any changes in the information on this form.

Patient Signature _____Date____/____/____Parent/Responsible Party _____

Reviewed by: _____ Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____
Address: _____
Telephone: _____-_____-_____
Social Security Number: _____-_____-_____

Section B: *****TO THE PATIENT***
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 PRACTICES: You have the right to read our Notice of Privacy Practices 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 other important materials about your protected health information. A copy of your Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in your 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.

You have been given a copy of our Notice of Privacy Practices. If you should need additional information please do hesitate to ask one of our staff.

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 our Administrative Staff. Please understand that 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.

Signature:

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 health care operations.

Signature: _____ Date: _____-_____-_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representatives Name: _____
Relationship to Patient: _____

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ATTENTION FOR ALL OUR PATIENTS

Due to the fact that there are many different programs to each insurance company, it has become almost impossible for the office to keep track of each patient's policy. Often your employer changes the coverage on a yearly basis to lower their costs and often changes your benefits from those of today. We do our best to help obtain this information for you, but you as a policyholder are responsible for obtaining this information prior to your visit to us. By calling the 800 number on the back of your insurance card, you can speak with a representative and confirm your benefits. Please read and sign the following:

I understand and accept any requirements or limitations placed upon me by my specific Insurance Plan. I am responsible for any deductibles stated in my insurance plan. I understand that I am solely responsible to know such limitations, if any, or requirements in order to receive dental services in your office. It is my responsibility to:

Know what my overages are and any limitations
Provide my co-payments for dental services at the time of care
After 31days, any unpaid balance is my financial responsibility

(Our office will continue to do our best to have your insurance company honor its responsibilities to you and have them reimburse you for your dental care.) But after 31 days it is the patients responsibility for any unpaid insurance balances.

I have read the above information and have had the opportunity to ask any questions about the same.

Print Name

Signature **Date**

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Dated: _____/_____/_____

To: _____

_____

_____

Re: _____

Please allow this letter to be my authorization to release my dental x-rays to:

Thuvan Vo, DMD
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Riverview, FL 33579
Tel: 813-671-0675
Fax: 813-671-0695

******If possible, we prefer to receive them digitally. If this is possible, please e-mail them to: vivispadental@gmail.com**

Sincerely,

Signature of Patient or Guardian: _____

Print Name: _____