Dr. Mylinh Duong, DDS, MS
2130 Thousand Oaks Dr., Ste 201
San Antonio, TX 78232
Phone: 210-654-7878

Name:_____ Marital Status:_____ Name of Spouse: _____

Social Security #:_____ DOB:_____ Height:_____ Weight:_____

Email: _____

Home Address:_____ City:_____ Zip: _____

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

Emergency Contact:_____ Relationship:_____ Phone #:_____

Your Dentist:_____ Your Physician: _____

Date of last Dental Visit:_____ for:_____

Health Evaluation:

Do you have or have you had any of the following:

HEART CONDITION	Y	N	CANCER	Y	N	KIDNEY DISEASE	Y	N
STROKE	Y	N	RADIATION THERAPY	Y	N	THYROID DISEASE	Y	N
RHEUMATIC FEVER	Y	N	ASTHMA	Y	N	SEVERE HEADACHES	Y	N
ANGINA/CHEST PAIN	Y	N	SHORTNESS OF BREATH	Y	N	GLAUCOMA	Y	N
HEART SURGERY	Y	N	EMPHYSEMA	Y	N	HIV/AIDS	Y	N
HEART STENT	Y	N	LUNG DISEASE	Y	N	STD/STI	Y	N
HEART BYPASS	Y	N	SEIZURE/EPILEPSY	Y	N	COLD SORES	Y	N
PACEMAKER	Y	N	JAUNDICE	Y	N	ANEMIA	Y	N
DEFIBRILLATOR	Y	N	HEPATITIS A, B, C	Y	N	ARTHRITIS	Y	N
LIVER DISEASE	Y	N	DIABETES- A1C:_____	Y	N	TUBERCULOSIS	Y	N
HIGH BLOOD PRESSURE	Y	N	LOW BLOOD PRESSURE	Y	N	JOINT REPLACEMENTS	Y	N

Are you pregnant or is there a chance you could be pregnant? **Y** **N**

Are you taking any form of birth control? Y N

Do you take aspirin on a regular basis? **Y** **N**

Have you taken cortisone or steroids within the past 2 years? Y N

Have you ever had instances of prolonged or unusual bleeding? Y N

Do you use tobacco products? Y N
If yes? How much/often? _____ .

Have you ever had stomach ulcers? Y N

Are you taking any antidepressants? Y N
*Certain anti-anxiety and/or antidepressants can change the efficacy of sedatives.

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... restoring healthy smiles

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

☐ Aspirin	☐ Penicillin/Amoxicillin	☐ Codeine
☐ Metal	☐ Acrylic	☐ Latex
☐ Sulfa Drugs	☐ Tetracycline	☐ Erythromycin
☐ Barbiturates	☐ Cephalexin	☐ Ibuprofen
☐ Tylenol	☐ Valium	☐ Ativan

Other Allergies:_____.

Please list all medications you are currently taking, including over the counter medications or supplements:

_____

_____

How would you describe your dental health? (Poor) 1 2 3 4 5 (Excellent)

Are your teeth sensitive to hot or cold?	Y	N			
Do you currently have a dental abscess?	Y	N	Are you currently taking antibiotics for abscess?	Y	N
Have you ever had orthodontic treatment (braces)?	Y	N	Are you currently still in orthodontic treatment?	Y	N
Do you have any problems chewing/eating?	Y	N	Have you noticed your teeth shift?	Y	N
Do you awaken with sore jaws in the morning?	Y	N	Do you clench or grind your teeth?	Y	N
Have you had gum treatment or gum surgery before?	Y	N	Are you interested in Oral/IV sedation for dental	Y	N

Do you notice clicking, popping, soreness in the joint in front of your ears? Y N

What concerns you most about your teeth and mouth? _____

_____

Do you have any disease, condition, or problem not listed in the previous Health Questionnaire? _____

_____.

Please list any surgeries or hospitalizations: _____

_____.

Does your physician require you to pre-medicate with antibiotics prior to dental procedures? Y N

Preferred Pharmacy: _____ Address: _____ Phone #_____
*(REQUIRED)

Patient Signature (or legal guardian):_____Name of patient if minor: _____

Date: _____

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Welcome!

Thank You for selecting our South Texas Periodontal Associates healthcare team! We will strive to provide you the best possible dental care. To help us meet all your needs, please fill out this form as completely as possible. This information is required in order for our office to file claims with your dental benefit provider. If you have any questions or need assistance, please ask! We will be happy to help.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature of Insured:_____ Date: _____

Mylinh Duong, DDS, MS (license # 35003)

2130 Thousand Oaks Dr., Ste 201, San Antonio, TX, 78232 Phone: 210-654-7878

Name of Insured:_____ DOB: _____

Is Patient a Full Time Student?_____ School:_____ City: _____

City, State, Zip: _____

Relationship to Patient:_____ SS#:_____

Date of Employed:_____ Name of Employer: _____

Union or Local#:_____ Work Phone#:_____

Address of Employer: _____

City, State, Zip: _____

Insurance Company:_____ Group#:_____

Policy ID #:_____

Insurance Company Address:_____

City, State, Zip: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I_____ have received and read a
(Print name of Patient)

copy of South Texas Periodontal Associates' Notice of Privacy Practices.

_____ _____
(Signature of Patient or Guardian) (Date)

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Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of_____'s dental needs. (Print name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consents to the Doctor or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that the only minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that any defaulted amount can and will be subjected to be placed in collections to any and all credit bureaus.

6. I understand and agree, if need be, to cancel any and all future appointments within a 48-hour notice. Failure to do so could result in a $25.00 Cancellation fee or 20% of my deposit on all future appointments. If I cancel my appointment 3 times without 48-hour notice, I am aware my full payment on any future treatment may be garnished or being dismissed from the practice. All future schedule appointments must be paid in full at the time the appointment is made. _____(Initial)

7. I also understand and agree that when applying for any financing for South Texas Periodontal Associates that a check of my credit score and or my credit history will be made. I am aware that I may be subjected to place 20% down by other means of payment if and when applying for financing. _____ (initial)

8. **Optional Photography Consent:**

    - I consent to have my photo taken and displayed in the office as part of contests or bulletin boards (initial choice below)
        - _____**I consent**
        - _____**I do not consent**
    - I consent to having my photo taken and posted as part of online social media including, but not limited to the office website and blog, Facebook, and Yelp. (Initial choice below)
        - _____**I consent**
        - _____**I do not consent**

Patient's Signature:_____Date: _____

Parent/Responsible Party's Signature: _____

Relationship to Patient: _____