Allen Tsai, D.D.S.

1400 Calloway Drive Ste #204
Bakersfield, CA 93312
Phone: 661-588-9499

Chart #:__________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date:______________
Last First MI

Preferred Name: ________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other__________

Social Security #: _________________ Birth Date:______________ Driver's Lic #:_______________

Phone (Home): _____________ (Work): ______________ Ext:_____ Best time to call: ___________

(Cell): ________________ E-mail: ____________________________ ☐ Yes, I would like email notifications/appt reminders

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: _______________ Reason for this visit:_____________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies
  ____
  ____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ ______________
- ☐ ______________
- ☐ ______________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Are you currently taking any medication(s)? ☐ Yes ☐ No
  If yes, please list: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____ Phone:_______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:________________
Signature of patient, parent or guardian

Emergency Contact Information

In the event of an emergency, whom should we contact?

Name: ___________________________ Relationship: ____________ Phone: (____) ____________

Name: ___________________________ Relationship: ____________ Phone: (____) ____________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:____ ☐ Male ☐ Female
Last First MI

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ______________ Ext:_____ (Cell): ______________

Address: ____
Street City State Zip Code

Patient Employment Information

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____

____

Secondary (if Applicable)

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____

____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other______________

Name of person or office referring you to our practice:______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A fee charge of $50.00 will be assessed if any appointments are missed or cancelled for any reason without a 24 hour notification call to our office, before your scheduled appointment date. As a note it would be best to make sure to speak with our receptionist if you are cancelling your scheduled appointment, as messages may sometimes not be received.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party