Ryan Tyng, D.M.D.
Medical/Dental History and Patient Information

Please fill out as accurately as possible. Please print.

Personal Information

Patient Name: ________________________________ Date of birth: ________________

Gender: ☐Male ☐Female ☐Married ☐Single ☐Other

If patient is a minor, Parent/Legal guardian name: ________________________________

Address: ________________________________ Apt/Suite: __________

City: ______________________ State: __________ Zip code: __________

Home phone: (____) ________________ Work Phone: (____) ________________

Cell phone :(____) ________________ Email: ________________________________

Insurance Information

Insurance company: ________________________ Employer: ________________

Primary policy holder: ☐ Self Spouse/Parent: ☐ Policy holder DOB: ___________

Policy holder name: ________________________________

Social Security Number: ________________________ Group #: ________________

Identification #: ______________________ I do not have insurance: ☐

The following information is required to accurately diagnose any condition, and to give you the highest possible standard of professional services. Please be as honest, and accurate as possible.

How often do you brush your teeth?

☐Less than 1x per day ☐1x per day ☐2x per day ☐3x per day

Do you floss? YES ☐ NO☐

If yes, how often? ☐ 1x per day ☐1-3x per week ☐4-6x per month

Allergies

☐ None ☐ Penicillin ☐ Asprin ☐ Nsaids ☐ Local Anesthetics ☐ Acrylic ☐Latex

☐ Sulfa ☐ Codeine ☐ Metal ☐ Seasonal ☐ Other, please list below

Are you currently experiencing any of the conditions listed below?	YES	NO
Arthritis	□	□
Asthma	□	□
Hay fever	□	□
Anemia	□	□
Diabetes	□	□
Blood disorder	□	□
Fainting spells	□	□
Sinus trouble	□	□
Tuberculosis	□	□
Ulcers	□	□
Nervous disorder	□	□
Blood pressure problems High/Low	□	□
Kidney disease	□	□
Congenital heart disorder or heart murmur	□	□
Hepatitis (A,B,C), jaundice, or liver disease	□	□
HIV Infection/AIDS	□	□
Lung or breathing disorder	□	□
Rheumatic fever, Scarlet fever	□	□
Seizures e.g. epilepsy or stroke	□	□
Do you have a history of substance abuse?	□	□
Are you currently using recreational drugs?	□	□
Do you smoke, or chew tobacco?	□	□

If yes, how much? ____

Cancer /tumors	□	□

If yes, when, and what type: ____

Joint Replacement	□	□

If yes, when, and which joint: ____

Are you pregnant? □
If yes, how many weeks? ________________ What is your due date? ________________

Have you had any recent surgical procedures? YES□ NO□

If you answered YES to any of the above medical conditions, please explain any further details regarding said condition:

Are you currently experiencing any conditions/illnesses that are NOT listed above? If yes list them below:

List any medications you are currently taking:

Consent for Treatment

I, ______________________________________, authorize Ryan Tyng, D.M.D, to perform any necessary dental services with my informed consent and assume all risks associated with treatment in the hope of achieving better dental and physical health.

I understand there are certain risks associated with the use of local anesthetic which can lead to bruising, muscle soreness, cardiac stimulation, and temporary or even permanent numbness to the lips or tongue. After lengthy appointments jaw muscles may be sore or tender. Gums and soft tissues may also be sensitive or painful during or after treatment. Although rare, it is possible for the tongue, cheeks, or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures.

I understand, that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, and the like, may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require sophisticated medical procedures by a licensed physician to remove safely.

____ Date: ____________________
Signature of patient, parent or guardian

HIPPA Patient Consent

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, at anytime. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). A detailed description of the HIPPA policy is available for your review upon request.

May we leave a recorded message regarding your financial responsibilities, or dental appointments on your home or cell phone number as provided? YES □ NO □

May we contact you by text or email regarding your appointment reminders?
YES □ NO □

____ Date: ____________________
Signature of patient, parent or guardian

Office Financial Policy

1. Our office provides insurance claim submission as a courtesy to our patients.
2. Copayments are due at time of service, unless prior payment arrangements have been made.
3. We accept cash, personal checks, Care Credit, and all major credit cards.
4. I agree to pay a fee of $40.00 for all returned or canceled checks.
5. I understand that there is a no show, or cancelation fee for missed appointments. This fee applies when an appointment is canceled with less than 48 hours notice, or if an appointment is missed without first alerting the office (no show, no call).

I, __________________________________, authorize Crossroads Family Dentistry to bill my dental insurance, and use my personal health information as necessary for billing purposes. I request my dental insurance to pay Crossroads Family Dentistry directly for services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I will be responsible for payment of dental services rendered on my behalf.

____ Date: ____________________
Signature of patient, parent or guardian