TRANSCENDENTAL LLC
Cosmetic & Family Dentistry

Thank you for selecting Transcendental!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to assist you .

Patient Information

Name: _____ Today's Date: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Primary Phone: ( ) _____ Secondary Phone: ( )_____
E-mail: _____ SSN #: _____

Check Appropiate Box:

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for referring you to our office? _____
Contact in case of emergency: _____ Phone: _____ Relation: _____

Responsible Party : Please provide information for person responsible for payment.

Name: _____ Relation to Patient: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Primary Phone: ( ) _____ Secondary Phone: ( ) _____
Responsible Party Signature: _____ Date:_____

Dental Insurance Information

Name of Insured: _____ Relation to Patient: _____
Date of Birth: _____SSN: _____ Phone: _____
Insurance Company: _____ Name of Employer: _____
Employer Address: _____ City: _____ State: _____ Zip Code:_____
Policy or ID No.: _____ Group No.: _____

Do you have additional Dental Insurance? ☐ **YES** ☐ **NO** If yes, please provide information below.

Name of Insured: _____ Relation to Patient: _____
Date of Birth: _____SSN:_____ Phone: _____
Insurance Company: _____ Name of Employer: _____
Policy or ID No.: _____ Group No.: _____

Patient's Name: _____ **Patient Date of Birth:** _____

Patient Medical History

Name of Physician: _____ **Phone No.:** _____ **Date of Last Exam:** _____

	YES	NO		YES	NO
1. Are you under medical treatment now?	☐	☐	10. Are you required to pre-medicate with antibiotics prior to treatment?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years? If yes, explain _____	☐	☐	11. Do you have a persistent cough not associated with a known illness (lasting more than 3 weeks)?	☐	☐
			12. Are you allergic to or have you had any reaction to the following:		
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐	Shellfish/seafood	☐	☐
			Peanuts/tree nuts	☐	☐
			Penicillin or any antibiotics	☐	☐
			Local Anesthetics (e.g. Novocain)	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐	Sulfa Drugs	☐	☐
5. Have you ever taken Fosamax, Boniva,Actonel or any bone density medication?	☐	☐	Barbiturates	☐	☐
			Sedatives	☐	☐
6. Have taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐	Iodine	☐	☐
			Aspirin	☐	☐
7. Do you use tabacco?	☐	☐	Any metals (i.e. nickel, mercury, etc.)	☐	☐
8. Do you use controlled substances?	☐	☐	Latex Rubber	☐	☐
9. Are you wearing contact lenses?	☐	☐	Other (please list) _____		

Women Only:

1. Are you pregnant or think you may be pregnant? _____ 2. Are you nursing? _____ 3. Are you taking oral contraceptives? _____

ALL PATIENTS: Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
Atrial Fibrillation	☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐
Asthma	☐	☐	Chest Pains	☐	☐	Hepatitis/Jaundice	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Cardiac Pacemaker	☐	☐	High Blood Pressure	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Heart Transplant	☐	☐	Recent Weight Loss	☐	☐
Artificial Joint	☐	☐	Epilepsy/Convultions	☐	☐	High Cholesterol	☐	☐	Respiratory Problems	☐	☐
Aids/HIV Infection	☐	☐	Emphysema	☐	☐	Hip/Knee Replacement	☐	☐	Sinus Problems	☐	☐
Alzheimer's	☐	☐	Easily Winded	☐	☐	Hemophilia	☐	☐	Shingles	☐	☐
Aneurysm	☐	☐	Fainting/Seizures	☐	☐	Kidney Diseases	☐	☐	Swollen Ankles	☐	☐
Back Problems	☐	☐	Frequently Tired	☐	☐	Low Blood Pressure	☐	☐	Stomach Trouble	☐	☐
Blood Transfusion	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐	Stroke	☐	☐
Chemical Dependency	☐	☐	Heart Trouble	☐	☐	Leukemia	☐	☐	Sexually Transmitted Disease	☐	☐
Circulatory Problems	☐	☐	Hayfever/Allergies	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐
Chronic Diarrhea	☐	☐	Heart Disease	☐	☐						

Patient Dental History

Name of Previous Dentist: _____ **Date of last dental exam:** _____

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	10. Do you bite your lips or cheek frequently?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐	11. Have you ever had any difficult extractions in the	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	past?		
6. Have you had any head, neck or jaw injuries?	☐	☐	12. Have you ever had any prolonged bleeding following	☐	☐
7. Have you ever experienced any of the following problems in your jaw?			extractions?		
			13. Have you had any Orthodontic treatment?	☐	☐
Clicking	☐	☐	14. Do you wear dentures or partials? If yes, what was	☐	☐
Pain (joint, ear, side of face)	☐	☐	the date of placement? _____		
Difficulty in opening or closing	☐	☐	15. Have you ever received oral hygiene instructions	☐	☐
Difficulty chewing	☐	☐	regarding the care of your teeth and gums?		
			16. Do you like your smile?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient Signature (Parent or Guardian if patient is a minor) **Today's Date**

_____ _____

Doctor Signature **Today's Date**

For office use only:

NO CHANGES CHANGES Patient Signature: _____ Date: _____

NO CHANGES CHANGES Patient Signature: _____ Date: _____

TRANSCENDENTAL L.L.C.
Cosmetic & Family Dentistry

Dear Valued Patient,

Welcome to our office!

I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability.

Therefore, the following policies must be agreed upon:

1. **No-shows are not acceptable**. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 24 hours of your appointment to reschedule. There is a $50.00 fee per half hour of your scheduled appointment for all no-show appointments and this fee is not covered by insurance. This money will be matched by Dr. Bui and donated to St. Jude's Children's Hospital.

2. **Timeliness is required**. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late for a half hour appointment or more than 15 minutes late for your one hour appointment, you may have to reschedule your appointment.

3. **Cleanliness and infection** control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse, and floss will be provided for you if needed.

4. **If you miss an appointment** you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

6. **We run a Zero Balance office.** We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. Please speak to the front desk staff if you have any questions.

7. **In order to schedule** an appointment with Dr. Bui, we require a deposit and a signed financial agreement.

8. **Our policy** is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

I greatly appreciate your cooperation.

Yours in Health,
Toan K. Bui, DMD

_____ _____

(Patient Signature) (Office Signature)

TRANSCENDENTAL LLC
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ **Date:** _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Would you like a copy of Transcendental's Notice of Privacy Practices? Circle one. YES NO

***I have received or revoked to receive, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

***I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may be on the type listed above. I understand that I have the right to revoke this consent at any time by giving written notice of my intent to revoke to Transcendental, LLC. I understand that revocation of this consent will not affect any action taken by Transcendental prior to receipt of revocation and Transcendental may decline to treat me or continue to treat me if I revoke consent.

***I acknowledge that routine protocol in this office is to leave confirmation messages on voicemail, answering machines or with another individual. I understand that postcards may be used to remind patients of future appointments promotional communication, such as birthday or holiday greetings, referral thank you letters and newsletters. I understand and consent to the office using electronic forms of communications, such as e-mail and text messages.

Signature:_____ **Date:** _____

If Patient is a minor:

Parent/
Legal Guardian Name:_____ Relationship to Patient:_____

THIS OFFICE IS IN COMPLIANCE WITH HIPAA STANDARDS. A COPY OF OUR OFFICE POLICY IS AVAILABLE UPON REQUEST.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

TRANSCENDENTAL LLC
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Patients with Dental Insurance

Treatment Recommendations are based on your health and not on your dental insurance or lack thereof. Dental Insurance is a contract between you and your insurance company. It is your responsibility to understand the guidelines set by your dental insurance company and/or policy. In most cases, we are **NOT** a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in being held fully responsible for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and amounts of payments they release. Should your insurance company pay less than estimated, the balance owed on your account, will become your responsibility. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

By signing this form, you authorize and request that your dental insurance company assign and distribute any insurance benefits to Transcendental, LLC directly, for any services rendered at our office.

Toan K. Bui, DMD

_____

Print Name

_____

Signature Date