Dr. Loi Ta, DDS
3313 N. Grimes
Hobbs, NM 88240
575-392-4290

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date _____

PATIENT INFORMATION

Name_____ Birthdate_____ SS#_____

Address_____ City_____ State _____ Zip_____

Home Phone (____)_____ Cell Phone (_____)_____ E-Mail _____

❒ Male ❒ Female ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Patient's (or Parent's) Employer_____ Work Phone (_____)_____

Spouse (or Parent's) Name _____ Employeer _____ Work Phone (___)_____ Cell (___)_____

If Patient is a Student, Name of School/College_____ City _____ State _____

Emergency Contact _____ Phone (____)_____ Cell (____)_____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate_____ SS#_____ Date Employed _____

Employer _____ Work Phone (_____)_____

Employer Address _____ City_____ State _____ Zip_____

Insurance Company _____ Group # _____ ID # _____

NOTICE OF PRIVACE PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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.

I have received, 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 the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____ _____
Signature Relationship to Patient Date

OVER

DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Visit _____

Former Dentist _____ Date of last Dental x-rays _____

Check ( ) if you have had any of the following:

❒ Bad Breath ❒ Grinding Teeth ❒ Sensitivity To Heat ❒ Clicking or Popping Jaw

❒ Loose Teeth ❒ Broken Fillings ❒ Sensitivity to Sweets ❒ Food Collection between teeth

❒ Bleeding Gums ❒ Periodontal Treatment ❒ Sensitivity to Cold ❒ Sores or growths in mouth

How often do you floss?_____ How often do you brush_____

MEDICAL HISTORY

Have you had any serious illnesses or operations? ❒ YES ❒ NO If yes, describe _____

_____

_____

Physician's name_____ Physician's Phone (____)_____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include combinations are AREDIA, ACTONEL, FOSAMAX or ZOMETA ❒ YES ❒ NO

If Yes, explain_____

(Women) Are you pregnant? ❒ YES ❒ NO Nursing? ❒ YES ❒ NO Taking Birth Control? ❒ YES ❒ NO

Check ( ) if you have had any of the following:

❒ Anemia ❒ Circulatory Problems ❒ Hemophilia ❒ Peanut Allergy

❒ Arthritis, Rheumatism ❒ Cortisone Treatments ❒ Hepatitis ❒ Rheumatic Fever

❒ Artificial Heart Valves ❒ Cough, Persistant ❒ High Blood Pressure ❒ Shortness of Breath

❒ Artificial Joints ❒ Cough up blood ❒ HIV / AIDS ❒ Skin Rash

❒ Back Problems ❒ Epilepsy ❒ Kidney Disease ❒ Swelling of Feet/Ankles

❒ Blood Disease ❒ Fainting ❒ Liver Disease ❒ Thyroid Problems

❒ Blood Transfusions ❒ Glaucoma ❒ Mitral Valve Prolapse ❒ Tobacco Habit

❒ Cancer ❒ Headaches ❒ Pacemaker ❒ Tonsillitis

❒ Chemical Dependency ❒ Heart Murmur ❒ Radiation Treatment ❒ Tuberculosis

❒ Chemotherapy ❒ Heart Problems ❒ Respiratory Disease ❒ Ulcer

❒ Venereal Disease

MEDICATIONS: List medications you currently take and correlating diagnosis:

_____

_____

_____

_____

_____

_____

_____

List Medical Allergies

_____

_____

_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered all questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits**. I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor_____ Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED