Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____ Email: _____

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

(Other): _____

Emergency contact: _____ Relationship: _____ Phone#: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Internet ☐ Flyer ☐ postcard ☐ Other _____

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

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____
Are you happy with your smile? ☐ Yes ☐ No
Have you ever thought about tooth whitening? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
Are your teeth sensitive to hot or cold? ☐ Yes ☐ No, Pressure? ☐ Yes ☐ No, Sweets? ☐ Yes ☐ No
Do you have a fear of dental work? ☐ Yes ☐ No

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

☐ AIDS-HIV
☐ Allergies _____
- ☐ Latex
- ☐ Metal
- ☐ Drug Allergies
  - ☐ Codeine
  - ☐ Penicillin
  - ☐ _____

☐ Anemia
☐ Arthritis
☐ Arteriosclerosis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Transfusion
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Cold Sores/Blisters
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Failure
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Current Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Sickle Cell Disease
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
OTHER:
☐ _____

Current Medication: Dose For

- Have you ever taken these medications?___Zometa____Aredia____Fosamax____Boniva____Actonel____Prolia
- Have you ever taken appetite suppresents-Fen-Phen(fenluramine&Phentermine) or Dexfenfluramine or Fenflurameine?
  ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- 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

Spouse or Responsible Party Information

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

Name: _____ ☐ Male ☐ Female

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

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

Insured's Employer Name: _____

Insured's Birth Date: _____ ID #: _____ SSN: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

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

Insured's Employer Name: _____

Insured's Birth Date: _____ ID #: _____SSN: _____ Group #: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Financial Agreement and Consent for Services

PLEASE NOTE: Our office does accept assignment of insurance benefits. Our acceptance does not absolve the responsible party of full responsibility for charges for treatment rendered. The estimate provided by our office is to be considered a guideline. We make every effort to be accurate in our estimation of benefits. However, since there is no way to be sure benefits have not been used in other offices, or that the policy is in effect at the time of service, this office can make no guarantee of the insurance payment as estimated. Your benefits are between you and your insurance carrier(s). Claims are submitted promptly after treatment is rendered. If your insurance hasn't paid within 45 days of submitted charges the charges will be considered your responsibility and payment in full is expected from the responsible party. We take great pride in helping you receive the maximum benefit from your insurance. We are always glad to answer your questions and help you in any way we can. DUE TO HIPPA requirements, your permission is necessary to submit secondary insurance if applicable.

We charge for all missed appointments at the rate of $25.00 per 15 minutes per provider. Forty-eight (48) hours notice is required to avoid this fee.

The patient/responsible party is responsible for total payment for procedures performed by Dr Zhu and her staff, including any balance not covered by insurance. I understand office policy requires my account be paid in full each month. If I desire or need to make monthly payments, application for payments needs to be made before the dental treatment has begun. All accounts are to be paid in full within 90 days of treatment regardless of insurance. I agree to pay all collection costs. I understand interest will be added to any unpaid balance at the rate of 1% (one percent) per month which is 12% (twelve percent) per year with a minimum charge of $2.50. I also understand additional late fees will be applied if my payment is not received within 15 days of the statement. I certify to have read, understood and agree to this.

_____Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Notice of Privacy Practices Consent

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date:_____

Patient Preference for Communication

I give my permission to staff and dentist to communicate my dental appointments, treatment, and related financial matters as described below:

I can be reached at the following phone numbers:

Home:_____
Work: _____
Cell:_____
Other:_____

Voice messages may be left at the above phone numbers **EXCEPT**_____

If I am unavailable you can share the information with family members **EXCEPT**_____

Text messages _____can _____can not be left on my cell phone_____for appointment reminders and other communication.

Email communication with me, my family or other referral doctors can be used with
____regular email (Risk: may be seen by other people)
____encrypted email (Risk: may lose information with lost password)
I understand the risk involved for communication method I choose.
My email address is: _____

Please feel free to ask our staff to discuss any issues in a private office.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your projected health information. A copy of our Notice is available to you - we encourage you to read it carefully and completely before signing this consent

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and other health care operations.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian