

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Male Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Questions

List any medications you are taking including nonprescription drugs:

Do you have any disease/problem you think we should know about? YES No

Are you allergic to any medications? YES No If yes, please list below:

Have you had a transplant operation that has depressed your immune system?
 YES No

Are you in good health? YES No

Have you had an allergic reaction to Bananas? YES No

Date of last medical exam: _____

Do you smoke or chew tobacco? YES No

Have you ever been hospitalized? YES No If yes, what was the problem

Have you had Heart Surgery? YES No

Are you now under the care of an MD? YES No

Are you taking or have you ever taken bisphosphonates?
 (Fosamax or Actonel for osteoporosis, chemotherapy, etc) YES No

FOR WOMEN ONLY:

Are you taking birth control pills? YES No

Are you nursing/breastfeeding? YES No

Are you pregnant? YES No

Expected delivery date: _____

Is there a possibility of pregnancy? YES No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Dental History Information

Date of last dental visit? _____

Do you snore? YES No

Name of your previous dentist _____

Do you have problems with bad breath? YES No

Reason for today's visit? _____

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? YES No

Have you ever had an oral cancer screening? YES No

Have you ever used an electric toothbrush? YES No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? YES No

Do your gums bleed when you brush? YES No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Have you ever had complications from an extraction? YES No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew? YES No

Whiter

Are you prone to frequent headaches? YES No

Straighter

Do you grind or clench your teeth? YES No

Close space

Do you have sores, blisters or swelling on your gums lips or cheeks? YES No

replace black mercury filling with tooth colored restorations

repair chipped teeth

Have you ever had orthodontic treatment? YES No

replace missing teeth

less gums showing

replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold Dr Loretta Chee or any other members of her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

Date:

Dr. Signature:

Date:

Reviewed by:

FINANCIAL POLICY

BASIC POLICY: Payment for services, including deductibles and co-pays, rendered is due in full at the time of service. Our office accepts cash, checks, and credit cards.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier, provided proper insurance information is given to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Co-pay or deductible will be based on the primary coverage if you have dual insurance coverage. Every effort will be made to closely **estimate** your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. The Practice cannot verify insurance benefits eligibility prior to treatment. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENT: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 48 hours' notice when canceling and appointment. There is a **\$50** fee for missed appointments without the 48-hour notification, which will be payable from you.

ASSIGNMENT OF INSURANCE BENEFITS for Patients with insurance coverage

I hereby assign all dental and/or surgical benefits, private insurance, and any other health plans, to Loretta Chee DDS until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME. With my signature below, I assume full responsibility for all payments on services rendered.

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID #: _____ Group #: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID #: _____ Group #: _____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Patient Signature

Patient Name

Date