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	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) ________			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

____

____

____

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

____

____

Are you in good health? ❑ YES ❑ No

Date of last medical exam: ________________

Have you had any surgeries? ❑ YES ❑ No If yes, what was the problem

____

____

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

____

____

____

____

Have you ever been pre-medicated prior to dental treatment? ☐ Yes ☐ No

Have you had any previous prosthetic joint infections? ☐ Yes ☐ No

Have you had a transplant operation? ☐ Yes ☐ No

Are you taking or have you ever taken bisphosphonates? ☐ Yes ☐ No

(Example: Fosamax or Actonel for osteoporosis, chemotherapy, etc.)

Do you smoke or chew tobacco? ☐ 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? ____________________

Name of your previous dentist ____________________

Reason for today's visit? ____________________

Have you ever had an oral cancer screening? ❑ YES ❑ No

How often do you floss your teeth? ____________________

Do your gums bleed when you brush? ❑ YES ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ YES ❑ No

Have you ever had complications from an extraction? ❑ YES ❑ No

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

Are you prone to frequent headaches? ❑ YES ❑ No

Do you grind or clench your teeth? ❑ YES ❑ No

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

Have you ever had orthodontic treatment? ❑ YES ❑ No

Do you snore? ❑ YES ❑ No

Do you have problems with bad breath? ❑ YES ❑ No

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

Have you ever used an electric toothbrush? ❑ YES ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ 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

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

- ❑ Whiter
- ❑ Straighter
- ❑ Close space
- ❑ replace black mercury filling with tooth colored restorations
- ❑ repair chipped teeth
- ❑ 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: ____________

Reviewed by: ____________ Date: ____________ Dr. Signature: ____________ Date: ____________

Financial policy

BASIC POLICY: Payment for services 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. All deductibles and co-pays are due at the time of service. 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. Please understand that insurance is a contract between you and your insurance company. 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. This assignment will remain in effect 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 Name:____________________ Address:_________________________
Phone Number:______________
Name of Insured: ______________________ Relationship:________________
ID #:_____________ Group #:___________

Secondary Insurance (if applicable):
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.

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Patient Signature Patient Name Date