Dr. John(Zhiyong) Fan DDS

1640 Highland Falls Dr. Ste 901

Leander, TX, 78641

Welcome!

Welcome to All Smiles Dentistry! Please fill out the form below (starred entries are required) and bring all your completed forms to the front desk with your **driver's license** and **insurance card.**

Date: _____ **Appointment time: _____**

Patient Information

Name (Last): _____
Name (First, MI): _____
Sex: _____ Birth Date: _____
SS# _____
DL#_____
Home Phone: _____
Cell Phone:_____
Email: _____
Address: _____
City: _____ State: _____ Zip:_____
Your Prefer contact by
Text _____Phone Call_____ Email_____

Insurance information

Primary Insured Name: _____
Birth Date: _____
SS#:_____
DL#_____
Relationship to Patient: _____
Employer: _____
Employer Phone #:_____
Insurance Company: _____
Group#: _____
ID#: _____

Contact Information

*Emergency Contact: _____
*Phone: (_____) _____ *Relationship: _____
Spouse: _____
Spouse's Phone: (_____)_____
Spouse's Employer: _____Position_____
*Your Primary Physician: _____
*Office Phone: (_____) _____
*Referred by: Patient: _____ Internet: _____
Zocdoc _____Insurance provider List _____Other: _____

NOTICE OF PRIVACY PRACTICES AND HIPAA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically on paper, or orally, are kept confidential. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect (04/14/03) and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

 # Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
 # Payment: We may use and disclose your health information to obtain payment for services we provide to you.
 # Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances.

 # In emergency situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
 # If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent.
 # If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we decide in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

PATIENT RIGHTS

You have the following rights with respect to your protected health information, which can be exercised by written request:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.
To request that we communicate with you about your health information by alternative means or to alternative locations.
The right to inspect and copy your protected health information.
If you request copies, we will charge you $25 for each set of X-Rays.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

Patient/ Guardian Name: _____ **Date: _____**

All Smiles dentistry Office and Financial Policies

Thank you for choosing All Smiles Dentistry to care for all your dental needs. Our goal as your dental care provider is to create a pleasant and comfortable experience both in the dental chair and at the financial desk. Please take some time to read over our Office Policies below so that we can establish a mutual understanding of any situations that could arise. Please read and initial each item below.

APPOINTMENTS:

- Please be on time for your reserved appointments. If you are fifteen or more minutes late for our appointment it will be considered a "no show" and rescheduled to another day. You will be assessed a $50.00 charge to your account. (Initials _____)
- If you need to cancel or reschedule an appointment, please let us know 48 hours in advance. If an appointment is cancelled or rescheduled within the 48 hours before the appointed time, $50.00 will be charged to your account. (Initials _____)
- For any appointment's scheduled for two hours or longer we require 20% NON-REFUNDABLE DEPOSIT of the total treatment scheduled for that day. We will retain the deposit if the appointment is cancelled or rescheduled within 48 hrs before the appointment. (Initials _____)

Fees and payment:

- New insurance information must be provided prior to my appointment date. I agree to provide this information before I am seen. Failure to provide correct insurance information may result in the entire bill being my own responsibility. (Initials _____)
- Estimated patient out of pocket and deductibles are due at every visit. If there is a deductible to meet, I will pay my estimated portion plus the deductible. I understand that the insurance benefits available are conditional on the patient's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. The benefits quoted are not a guarantee of payment. Final determinations to benefits payable will be made at the time the claim is submitted for payment. Benefits not paid by the insurance company are the responsibility of the patient. (Initials _____)

- After my insurance plan has processed the insurance claim, remaining balances are due immediately upon receipt of a bill from the office. If I disagree with the amounts due per the insurance Explanation Of Benefits, it is my responsibility to immediately contact my insurance company for resolution of the problem. I understand that I may not withhold payment to All Smiles Dentistry pending resolution of the insurance problem. If the insurance corrects the problem, I understand my account will be credited or I will be refunded any overpaid amounts. (Initials _____)
- A $25 fee will be incurred if a check is returned. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. If a second check is returned on my account, I understand that the office will no longer accept personal checks for payment. (Initials _____)

Again, we thank you for choosing All Smiles Dentistry to care for your dental needs. We appreciate your trust and look forward to serving you. If you have any questions regarding our financial policies, please don't hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that you were provided with a copy for your records.

Parent/Guardian Printed Name _____

Signature of Patient/Guardian _____ Date _____

Dental History

Your most concern is: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How would you rate the condition of your mouth? Excellent___ Good___ Fair___ Poor____

I routinely see my dentist every 3 Month___4 Month___ 6 Month___12 Month____ Not routinely___

Are you sensitive to (check all that apply) :	□Heat	□ Cold	□Sweets
Do you (check all that apply):	□Grind your teeth		□Wear a night
guard Do you have (check all that apply):	□Clicking	□Popping	□Pain in Jaw Joints
Do your gums bleed when you brush teeth?		□Yes	□No
Are you experiencing pain in your mouth at this time?		□Yes	□No
Have you noticed any loose or shifting teeth?		□Yes	□No
Have you experienced bad breath/ bad taste in your mouth?		□Yes	□No
Have you worn braces or Invisalign?		□Yes	□No
Do you smoke Cigarette/Pipe/Cigar		□Yes	□No
Do you have Food collection between teeth?		□Yes	□No
Do you have pain around ear?		□Yes	□No

Smile Evaluation:

This is a simple questionnaire to help you obtain the smile you've always wanted. Hold a full-face mirror 12-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully as you answer the following questions.

Do you like the appearance of your teeth and smile? ____ Yes ____ No

Are your teeth all in alignment (straight)? ____ Yes ____ No

Do you have spaces that you don't like? ____ Yes ____ No

Do you like the color of your teeth? ____ Yes ____ No

Do you like the shape of your teeth? ____ Yes ____ No

Are your teeth ____ Chipped ____ Protruding ____ Hidden?

Do you like the way your teeth come together? ____ Yes _ ___ No

Are there old fillings or dental work that you don't like looking at? ____ Yes ____No

Do you ever have braces, orthodontic treatment or had your bite adjusted? ____ Yes ____No

Have you ever whitened(bleached) your teeth? ____Yes ____ No

What would you like to change most in the appearance of your smile? _____

Allergies

Are you allergic to any of the following?

Aspirin	Yes / No	Codeine	Yes / No
Iodine	Yes / No	Latex	Yes / No
Penicillin	Yes / No	Sulfa	Yes / No
Local Anesthetic	Yes / No		

Barbiturates (sleeping pills) Yes / No Other: _____

For WOMEN

Are you pregnant? Yes / No

If yes, when are you due? _____

OBGYN Name & Phone Number:

_____

Taking birth control pills? Yes / No

Are you nursing? Yes / No

Medical History

Primary Physician Name: _____ Phone Number: _____
What would you consider of your general health? Excellent____ Good ____ Fair ____Poor_____
Hospitalized for illness or injury recently? _____
Are you easy bleeding or take any blood thinner? _____
Do you have Tuberculosis? _____
Do you have cardiac stent/ pacemaker/artificial valve in the last 6 months? _____
Do you have any joint replacement in the last 6 months? _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)Do you have, or have you had, any of the following? Y/N

AIDS/HIV	Yes / No	Emphysema	Yes / No	Respiratory Disease	Yes / No
Anemia	Yes / No	Epilepsy	Yes / No	Rheumatic Fever	Yes / No
Arthritis/Rheumatism	Yes / No	Fainting or dizziness	Yes / No	Scarlet Fever	Yes / No
Artificial heart valves	Yes / No	Glaucoma	Yes / No	Shortness of breath	Yes / No
Artificial joints	Yes / No	Headaches	Yes / No	Sinus trouble	Yes / No
Asthma	Yes / No	Heart murmur	Yes / No	Skin rash	Yes / No
Back problems	Yes / No	Heart problems	Yes / No	Special diet	Yes / No
Bleeding abnormally with extractions or surgery	Yes / No	Hepatitis B	Yes / No	Stroke	Yes / No
Blood disease	Yes / No	Hepatitis C	Yes/No	Swollen feet or ankles	Yes / No
Cancer	Yes / No	Herpes	Yes / No	Swollen neck glands	Yes / No
Chemical dependency	Yes / No	High blood pressure	Yes / No	Thyroid problems	Yes / No
Chemotherapy	Yes / No	Jaundice	Yes / No	Tonsillitis	Yes / No
Circulatory problems	Yes / No	Jaw pain	Yes / No	Tuberculosis	Yes / No
Congenital heart lesions	Yes / No	Kidney disease	Yes / No	Tumor or growth on head or neck	Yes / No
Cortisone treatments	Yes / No	Liver disease	Yes / No	Ulcer	Yes / No
Cough persistent	Yes / No	Low blood pressure	Yes / No	unexplained Weight loss	Yes /No
Diabetes	Yes / No	Mitral Valve Prolapse	Yes / No	contact lenses	Yes / No
		Nervous problems	Yes / No		

I certify that I have read this form in its entirety and acknowledge this information is correct to the best of my knowledge:

Parent/Guardian Printed Name _____

Signature of Patient/Guardian _____ Date _____