New Patient Paperwork

Dr. Sarah Ohkyoung Chang DDS

The medical history assists us in providing you with excellent dental care for a happy and comfortable environment. Thank you for completing the following confidential information. **ALL FORMS MUST BE SIGNED, BOTH PAGES FRONT AND BACK**

Your Child

Child's Name:_____

Nick Name:_____Sex:_____

Birthday:_____Age:_____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____

Responsible Party

Name:_____

Relationship:_____

Address:_____

City:_____Sate:_____Zip:_____

Email:_____

Who may we thank for referring you to our office? :_____

Mother __ Stepmother or __ Guardian

Name:_____

Phone number:_____

Work Number:_____

Email:_____

Employer:_____

Occupation:_____

Date Of Birth:_____

Father __ Stepfather or __ Guardian

Name:_____

Phone number:_____

Work number:_____

Email:_____

Employer:_____

Occupation:_____

Date of Birth:_____

Emergency contact:_____ phone number:_____

Insurance

Some insurances require the subscriber's SSN # if a member id is not provided

Insurance Company:_____ Phone #:_____ Employer:_____

Member Id or SSN:_____ Subscriber's Name:_____

Subscriber's Date of birth:_____ Relationship to patient:_____

Primary Dental Concerns:_____

_____

Medical History: Please Indicate if your child has or has had any of the following? Please "X" all that may apply

	Heart Disease		Sinusitis, Hay Fever		Digestive Disorder		Genetic Disorder		Obesity
	Asthma		Seizures		Heart Murmur		Cancer		Sleep Apnea
	Chronic Cough		Epilepsy		Anemia		Cleft Lip/Palate		Neuromuscular Disorder
	High Blood Pressure		Nervous Disorder		Feeding Tube		ADHD/ADD		Sensory Disorder
	Kidney Trouble		Thyroid Disorder		Autistic		Liver Disease		Ulcer
	Speech Delay		Developmental Delay		Immune Deficiency		Cerebral palsy		G.I Issues
	Diabetes		Bleeding Disorder		Sickle Cell Disease		Psychiatric Treatment		Depression

Other/ Explain:_____

Please Indicate if your child has Allergies: Please "X" all that may apply

	Aspirin		Codeine		Local Anesthetic		Penicillin		Dairy		Latex		Nuts

Others:_____

List of current medications:_____

Pediatrician: _____ Pharmacy Phone #:_____

Other Healthcare Providers:_____

ENT:_____ Orthodontics:_____

Dental History

Yes	No	
		Has your child ever been hospitalized?
		History Of Surgery?
		Was your pregnancy full term? If Not, how long:_____
		Frequent antibiotic usage?
		Did you Nurse or Bottle feed? To what age?:_____
		Is your child in any therapy? Explain:_____
		Does your child sleep through the night?
		Does your child snore?
		Habits: Pacifier, nail biting, finger biting, Chewing on ice, Thumb sucking
		Predominantly Mouth breathing
		Jaw Popping or pain while chewing, Deviate, Clicking
		Frequent Headaches
		Picky Eater
		Has your child's Tonsils/ Adenoids been removed? Explain:_____
		Eartubes? Explain:_____
		Previous dental trauma? Explain: _____

Consent

The undersigned hereby authorizes Dr. Sarah Ohkyoung Chang DDS and associates to take radiographs, diagnostic models, photographs, or any other diagnostic aids deemed necessary to perform a through diagnosis.

Patient Name:_____ Date:_____

Parent/Guardian signature:_____ Relationship:_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

Information (PHI). Theses restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____Relationship to Patient _____

FINANCIAL POLICY

Payment is due in full at time of treatment

The responsible party agrees:

1. To make payment in full at time of treatment or service.
2. To be responsible for additional cost and/or responsible attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.
3. To pay a 40% collection fee, which will be added to the outstanding balance.

I understand that I am financially responsible for all charges whether or not paid by insurance. Also, I am aware that if I fail to show to my scheduled appointment or give less than a 24 business hour notice I will be charged a $25.00 no show fee.

Signature _____ Date _____

Office Policies

Broken Appointments

- A broken appointment is defined as a missed or canceled appointment without giving 24-hour notice, a broken appointment fee of $25.00 will be added to each child(ren) account. Each patient will be allowed 2 broken appointments after which a referral will be given to another dental office.
- Any new patients that have missed the first appointment without a 24-hour notice will be given a referral to another dental practice and will not be scheduled again.
- **Any appointments missed on a student holiday/vacation will not be rescheduled on another student holiday/vacation.**

Grace Period

- There is a 15-minute grace period for appointments scheduled from 8:00 am to 2:00 pm. Appointments scheduled from 2:30 pm to 3:00 pm have a 10-minute grace period. Any time past may result in an appointment change, or a missed appointment fee may be applied.

Financing

- **Payment for services is due at the time services are rendered**. We will accept cash, checks, and all major credit cards. As a service to our patients, we electronically process most insurance claims. If we are unable to process a claim, we will provide you with all documentation necessary to process the claim yourself. If insurance is filed, you will be responsible for your estimated portion at the time of service. **If insurance denies a portion of your claim, you will be responsible for the difference.**
- The Treatment Plans we will provide you with are an **estimate of costs** for your child(ren) needed treatment. The costs can change as the treatment progresses as well as the ongoing evaluations of your child(ren) dental care.
- **We DO NOT file secondary insurance or medical insurance.**
- **We do not accept same day insurance: we require at least 48-hour notice for new insurance information to avoid paying out of pocket for your child(ren) appointment.**

I have read and agreed to the terms provided.

Patient Name:_____

Parent/Guardian (print):_____

Parent/Guardian (sign):_____ Date:_____