



## 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**

### ***Your Child***

Child's Name: \_\_\_\_\_

Nick Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

### ***Responsible Party***

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ 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: \_\_\_\_\_

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**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
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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). These 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 than 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 to 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 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: \_\_\_\_\_