GREENLAKE DENTAL
– EST. 2001 –

# HEALTH HISTORY AND REGISTRATION

## PATIENT INFORMATION

**NAME**: LAST_____FIRST_____MI_____SEX: M F

BIRTH DATE: _____/_____/_____AGE: _____SS#_____-_____-_____ MARITAL STATUS: S M W D

ADDRESS _____CITY_____

STATE _____ ZIP _____ CELL PHONE _____

HOME PHONE _____ EMAIL _____ OCCUPATION _____

EMPLOYER _____YEARS EMPLOYED: _____ WORK PHONE_____

WORK ADDRESS_____CITY_____STATE _____

**SPOUSE INFORMATION**: NAME_____OCCUPATION_____

EMPLOYER_____SS# _____-_____-_____BIRTH DATE_____/_____/_____

WORK PHONE _____ CELL PHONE _____

**HOW DID YOU HEAR ABOUT US?**_____

## EMERGENCY CONTACT

NAME: _____RELATIONSHIP: _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

## DENTAL INSURANCE INFORMATION

INSURANCE CO. _____ INSURANCE PLAN _____ PHONE _____

GROUP # _____ MEMBER # _____ HOLDERS NAME_____

BIRTH DATE_____/_____/_____ SS# _____-_____-_____CONTACT NUMBER_____

DO YOU HAVE SECONDARY INSURANCE_____ IF SO WHAT CO._____PHONE_____

GROUP #_____MEMBER#_____HOLDERS NAME_____

## FOR OFFICE USE ONLY

DEDUCTIBLE _____MAX_____PREVENTATIVE_____BASIC_____MAJOR_____

FLUORIDE_____ MEDICAL ALERTS _____

***BOTH SIDES PLEASE***

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IT IS IMPORTANT THAT THE MEDICAL AND DENTAL INFORMATION PROVIDED IS CURRENT AND ACCURATE. FOR DR CHANG AND HIS ASSOCIATES TO PROVIDE SAFE AND EFFECTIVE DENTAL CARE, IT IS NECESSARY FOR THEM TO KNOW YOUR MEDICAL AND DENTAL HISTORY. THANK YOU FOR TAKING YOUR TIME TO FILL OUT THIS FORM COMPLETELY.

## DENTAL HISTORY

NAME OF PREVIOUS DENTIST_____PHONE_____

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? _____ DATE OF LAST X-RAYS_____

REASON FOR YOUR DENTAL VISIT TODAY_____

DO YOU GRIND YOUR TEETH AT NIGHT? YES NO
DO YOU HAVE TROUBLE SLEEPING? YES NO

DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER? YES NO

DO YOU FLOSS REGULARLY? YES NO

ARE YOUR TEETH SENSITIVE TO (PLEASE CIRCLE) HOT SWEETS COLD PRESSURE

DO YOU HAVE HEADACHES, EARACHES OR NECK PAIN? YES NO

HAVE YOU WORN BRACES ON YOUR TEETH? YES NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES NO

IF NOT, PLEASE EXPLAIN _____

## MEDICAL HISTORY

PHYSICIANS NAME_____ PHONE #_____

ARE YOU CURRENTLY UNDER A PHYSCIANS CARE? YES NO IF SO, FOR WHAT? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

_____

DO YOU USE ANY TYPE OF TOBACCO PRODUCTS? YES NO IF SO, WHAT? _____

(FOR WOMEN ONLY) ARE YOU PREGNANT? YES NO IF NOT, ARE YOU NURSING? YES NO

PLEASE **CHECK YES** OR **NO** OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Alcoholism | ☐ | ☐ | Emphysema | ☐ | ☐ | HIV/AIDS positive | ☐ | ☐ | Rheumatic/Scarlet fever |
| ☐ | ☐ | Allergies | ☐ | ☐ | Epilepsy | ☐ | ☐ | Jaundice | | | |
| ☐ | ☐ | Anemia | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Rheumatism |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Fainting | ☐ | ☐ | Liver Disease | ☐ | ☐ | Seizures |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Glaucoma | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Sinus problems |
| ☐ | ☐ | Artificial Joints | ☐ | ☐ | Growths | ☐ | ☐ | Nervous Disorders | ☐ | ☐ | Smoking |
| ☐ | ☐ | Asthma | ☐ | ☐ | Hay Fever | ☐ | ☐ | Pacemaker | ☐ | ☐ | Stomach Problems |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Head injuries | ☐ | ☐ | Pain in jaw joints | ☐ | ☐ | Stroke |
| ☐ | ☐ | Cancer | ☐ | ☐ | Heart Disease | ☐ | ☐ | Pregnancy | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Heart murmur | ☐ | ☐ | Psychiatric care | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Hemophilia | ☐ | ☐ | Radiation treatment | ☐ | ☐ | Tumors |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Hepatitis | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Drug Abuse | ☐ | ☐ | High Blood Pressure | | | | ☐ | ☐ | Venereal Disease |

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Aspirin | ☐ | ☐ | Sulfa | ☐ | ☐ | Ibuprofen | ☐ | ☐ | Tetracycline |
| ☐ | ☐ | Latex | ☐ | ☐ | Local Anesthetic | ☐ | ☐ | Erythromycin | ☐ | ☐ | Amoxicillin |
| ☐ | ☐ | Codeine | ☐ | ☐ | Nitrous Oxide | ☐ | ☐ | Penicillin | ☐ | | _____ |

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____ DATE:_____

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# OFFICE POLICIES

**Welcome to our practice and thank you for choosing us as your dental care providers. We are committed to your treatment being successful. All patients must complete and sign our information/new patient form prior to any treatment. We ask that you please read the following office policies to familiarize yourself with our office. After reading, please sign below. Thank You**.

## FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Estimates for major dental care are available. A monthly financial fee of 18% is applied to balances not paid by the 1st of the following month after treatment. There will be a $35.00 handling fee, in addition to any bank charges for any returned checks. For your convenience we accept cash, checks, Visa, Master Card.

## REGARDING INSURANCE

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do accept assignment of benefits, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We are unable to bill your insurance company unless you give us your complete insurance information. In the event that you need referral to a specialist to complete your treatment, your insurance company will not fully pay your bill at the specialist's office. It is your responsibility to contact your insurance and the specialist's office directly prior to your appointment to discuss your coverage.

We allow 60 days for your insurance company to pay. In the event your insurance has not paid within a 60-day period, the bill will then be turned over to you and you will be responsible to pay within the next 30 days. At that time we also resubmit to your insurance company for the last time. A simple call to your insurance company for you will greatly facilitate the payment. Remember, payment for your dental bill is always your responsibility. We allow your insurance company 60 days to pay as a service to you. All percentages and deductibles are due in full at the time of treatment.

Remember, what we collect from you at the time of visit is only an estimate. After receiving your insurance payment, we will bill or credit your account the difference.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usually and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary, out-dated determination of usual and customary rates.

## APPOINTMENTS AND SCHEDULING

Please remember that once you make an appointment, the doctor's time, treatment room, and support personnel have been reserved specifically for YOU. When we set aside this reserved appointment time for you we will consider it as time you have committed. If you feel that you require a reminder phone call, please request this from our staff. **Unless cancelled at least 48 business hours in advance, our policy is to charge $75.00 per missed hourly appointment.** If a missed appointment does occur, we would ask you to pay your missed appointment fee prior to being seen. If a second missed appointment occurs, we ask that you pay your missed appointment fee prior to scheduling your next appointment. If a third missed appointment occurs, we ask that you take the time to find a new dental care provider. When patients fail to arrive for the appointments they scheduled, that time is lost which could have been used to treat other people in need. Please help us serve you better by keeping the appointments you schedule.

Your time is valuable to us. We try to stay on schedule and most of the time we do. We ask that you help us to do this by arriving at least 5 minutes prior to your appointment. **In order to keep our office operating on time, it may be necessary to reschedule your appointment if you are more than 15 minutes late.** If uncontrollable circumstances have occurred to make you up to 15 minutes late, there may be a possibility that you may still be seen. However, other patients that are currently scheduled will be seen first. Despite our best intent, treatment emergencies do, on occasion, arise in our schedule causing unavoidable delays. We will apprise you of any such circumstance at the earliest possible opportunity to avoid any inconvenience for you.

## MINOR PATIENTS

The parent, adult, or guardian accompanying the child during the child's appointment, is responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, payment by cash or check at the time of service.

**THANK YOU FOR READING AND SIGNING OUR POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS**

## I HAVE READ THE POLICIES AND I UNDERSTAND AND AGREE TO THEM

| NAME (PLEASE PRINT) | SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | DATE |
|---|---|---|

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health 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. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

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 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.**