Patient Information

Patient Name: _____ Birth Date: _____ Male/Female
Last First MI

__Married __Single __Child Social Security#_____

Address: _____ Apt#_____

_____ _____ _____
City State Zip

How did you hear about our office? _____

Responsible Party Information

The following is for the person responsible for payment: __self __spouse __parent/guardian

Patient Name: _____

Birth Date: ___-____-_____ Social Security #: _____-____-_____
mo day year

Phone (Home): _____(work):_____(Cell): _____

E-mail: _____ Fax: _____

Address: _____ Apt#_____

_____ _____ _____
City State Zip

Insurance/Dental Plan Information

Primary Plan Name: _____ Group#: _____Member ID: _____

Insurance Address: _____

Insurance Phone #: _____

Employer: _____

Policy Holder's Name: _____

Social Security #: _____ Birth Date: _____

Secondary Plan Name if applicable:_____ Group#: _____Member ID: _____

Insurance Address: _____

Insurance Phone #: _____

Employer: _____

Policy Holder's Name: _____ SS#: _____ Birth Date: _____

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for Today's Visit: _____

Have you ever had any of the following? Please check all that apply:

__AIDS/HIV+
__Allergies:
_____
_____
__Anemia
__Arthritis
__Artificial Joints
__Artificial/Leaky Heart Valve
__Asthma
__Blood Disease
__Bruise Easily
__Cancer
__Cold Sores/Fever Blisters
__Contact Lenses
__Cortisone med.
__Restricted Diet
__Dizziness
__Emphysema
__Epilepsy
__Excess Bleeding
__Fainting
__Glaucoma
__Growth
__Hay Fever
__Head Injuries
__Heart Attack/ Disease/ Surgery
__Heart Murmur
__Hemophilia
__Hepatitis
__High BloodPressure
__Diabetes
__Kidney Disease
__Latex Sensitivity
__Liver Disease
__Mental Disorders
__Mitral Valve Prolapse
__Nervous Disorders
__Pacemaker
__Psychiatric/ Psychological Care
__Pregnancy: ___wks
__Radiation Treatment
__Respiratory Problem
__Rheumatic Fever
__Rheumatism
__Sinus Problems
__Smoking/Chewing
__Jaundice
__Stomach Problems
__Stroke
__Thyroid Problems
__Tuberculosis
__Tumors
__Ulcers
__Codeine Allergy
__Penicillin Allergy
__Aspirin Allergy
__Allergic/Adverse Reaction to Med or Any Substance: ___
_____
__Pre-medication w/ antibiotics prior to dental visits

*Have you ever taken any of the following osteoporosis medications: Zometa, Aredia, Fosamax or Actonel? __Yes __No If yes, please list. _____

*Have you ever had any complications following dental treatment? __Yes __No If yes, please explain.
_____

* Have you ever been admitted to a hospital or needed emergency care during the past two years?

__Yes __No If yes, please explain. _____

*Are you now under the care of a physician? __Yes __No If yes, please explain.
_____

*Name of Physician: _____ Phone: _____

*Do you have any health problems that need further clarification? __Yes __No If yes, please explain.
_____

*Are you taking any medications? Purpose? Please list. _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without failure.

_____ Date: _____
Signature of patient, parent or guardian

Cancellation of Appointments

I agree to keep all scheduled appointments unless I notify the office at least 24 hours prior to the appointment. I understand that failure to keep a scheduled appointment may result in a missed appointment fee of $50. However, if we are able to fill your appointment spot with less than 24 hours notice, you will not be charged.

_____ Date: _____
Signature of patient, parent or guardian

Consent for Services and Financial Information and HIPAA Information

Consent : I hereby authorize Dr. Song, his associates and his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Song, his associates to make a thorough diagnosis of me/my charge's dental needs. Upon such diagnosis, I authorize Dr. Song and his associates to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

Financial Information : As a courtesy, this office will help prepare and submit your insurance forms. However, I understand that any fees not covered by insurance are my final responsibility. By signing this form, I authorized this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

I understand that any fee estimated provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of service. A service charge of 18% per year will be charged to my account on any unpaid balance or the account will be sent to collection agency unless previously written financial arrangements are made. I understand that 3rd party financing options such as Care Credit are available to assist with payments. I understand that in order to be approved for any payment plan options that a credit report may be run. By signing this form, I authorize a credit check to be administered if I am asking for credit to be extended to me.

I understand that in the event that I default in the payment of fees due to Dr. Song and his associates, I will be responsible for all expenses incurred by Dr. Song and his associates including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies.

HIPAA Information : 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). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatments by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatments, payment and health care options but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to all of their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party