DENTAL REGISTRY AND HISTORY

PATIENT INFORMATION

Date____

Patient Name_______________________________________
Last Name

____
First Name Middle Initial

Address____

City____________________State_______Zip____________

Sex ☐M ☐F

Birthdate___________ ____ Age______________

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Patient Employer___________________________________

Occupation____

Patient SS#____

Spouse's Name______________________________________

Phone Numbers (_____)____________(_____)____________
Home# Cell Phone#

(______)________________ ________ ____________________
Work# Ext (Best time to reach you)

Who is responsible for this account?_______________
Print name

Email____

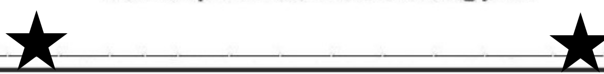
Emergency Contact Information

Name_________________________Relationship__________

Home Phone (____)________ ___ Work Phone(____)________

____

Who may we thank for referring you?



ARE YOU HAPPY WITH YOUR SMILE?

Are you happy with your smile?________

Take a personal smile test:
A= Love it
B= Acceptable
C= Could be better
D= Don't like it
F= Don't like it at all
NP= Not a problem

Comments________________

____

____

Grade your smile

Whiteness________________

Staining/discoloration______

Evenness of teeth__________

Chipping or Cracking ______

Existing dental work_______

Gum Health / Appearance___

Smile line_______________

DENTAL INSURANCE

Subscriber's Name__________________________________

Insurance Co.______________________________________

Group#____

Relationship to Patient____________________________

Employer____

Birthdate_________________SS#______________________

I certify that I, and /or my dependent(s), have insurance coverage with ______________and assign directly to Dr. ______________

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please Print Name Date

DENTAL HISTORY

Reason for today's visit___________________________

____

Date of last dental visit__________________________

Date of last dental X-rays_________________________

Please circle to indicate if you have had any of the following:

Bad breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue
Chew on one side of mouth
Clicking or popping jaw
Dry Mouth
Fingernail biting
Food collection between the teeth
Grinding teeth
Gums swollen or tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing
Mouth pain, brushing
Orthodontic treatment
Sores or growth in your mouth

Pain around ear
Periodontal treatment
Sensitivity to cold
Sensitivity to heat
Sensitivity to sweets
Sensitivity when biting

How often do you floss?

____

How often do you brush

____

HEALTH HISTORY

Physician's Name _________________________ Phone#_________________________ Date of Last Visit__________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combination of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Y/N

Please Circle Y/N to indicate if you have had any of the following:

Aids/HIV	Y/N	Epilepsy	Y/N	Respiratory Disease	Y/N
Anemia	Y/N	Fainting or dizziness	Y/N	Rheumatic Fever	Y/N
Arthritis, Rheumatism	Y/N	Glaucoma	Y/N	Scarlet Fever	Y/N
Artificial Heart Valves	Y/N	Headaches	Y/N	Shortness of Breath	Y/N
Artificial Joints	Y/N	Heart Murmur	Y/N	Sinus Trouble	Y/N
Asthma	Y/N	Heart Problems	Y/N	Skin Rash	Y/N
Back Problems	Y/N	Hepatitis type_____	Y/N	Special Diet	Y/N
Bleeding abnormally, with extractions or surgery Y/N		Herpes	Y/N	Stroke	Y/N
		High Blood Pressure	Y/N	Swollen Feet or Ankles	Y/N
Blood Disease	Y/N	Jaundice	Y/N	Swollen Neck Glands	Y/N
Cancer	Y/N	Jaw Pain	Y/N	Thyroid Problems	Y/N
Chemical Dependency	Y/N	Kidney Disease	Y/N	Tonsillitis	Y/N
Chemotherapy	Y/N	Liver Disease	Y/N	Tuberculosis	Y/N
Circulatory Problems	Y/N	Low Blood Pressure	Y/N	Tumor or growth on head or neck	Y/N
Congenital Heart Lesions	Y/N	Mitral Valve Prolapse	Y/N		
Cortisone Treatments	Y/N	Nervous Problems	Y/N	Ulcer	Y/N
Cough, persistent or bloody	Y/N	Pacemaker	Y/N	Venereal Disease	Y/N
Diabetes	Y/N	Psychiatric Care	Y/N	Weight Loss, Unexplained	Y/N
Emphysema	Y/N	Radiation Treatment	Y/N	Any history of smoking	Y/N

Do you wear contact lenses? Y/N

Women

Are you pregnant? Y/N Due Date_______________ Are You Nursing? Y/N

Taking Birth Control Pills? Y/N

MEDICATIONS

List any medications you are currently taking and
The correlating diagnosis:
____

____

Pharmacy Name ____

Phone (____)____

ALLERGIES

Y/N Aspirin
Y/N Barbiturates (Sleeping Pills)
Y/N Codeine
Y/N Iodine
Y/N Latex
Y/N Local Anesthetic
Y/N Penicillin
Y/N Sulfa

Other_______________________________________

I affirm that information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient's or Parent's
Signature__________________________Date_______________Doctor's Signature______________

MEDICAL HISTORY UPDATES

Date_____________Comments____

____Signature______________________Signature_________________
(Patient's) (Doctor's)

Date_____________Comments____

____Signature______________________Signature_________________
(Patient's) (Doctor's)

Patient Financial Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services provided. To assist us in achieving these goals, we ask that you review out financial policy. If you have any questions about our policies and/or your responsibilities simply ask one of our friendly and knowledgeable team members. We are here to assist you.

Payment Options: We accept cash, checks, Visa, MasterCard, American Express, and Discover. We also accept Care Credit payment options.

Financial arrangements must be settled to reserve appointment time. When scheduling your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy.

Insurance: As a courtesy to our patients and at your request, we will be happy to file your claim with the Insurance Company based on the information that you have provided to our office..

Please be aware that verification of benefits and filing of a claim does not guarantee payment. The determination of whether the claim is paid is made by the insurance Company when they receive the claim. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation or your carrier's pre-estimate.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. Our office will submit your claim to your insurance twice if necessary. Additional submissions are the patient's responsibility. If your insurance company has not paid the full balance of the claim within 60 days from the treatment date, you will be responsible for the balance.

Missed Appointments: Once an appointment has been made, please remember that this time has been specifically reserved for you. No charge will be made for rescheduling an appointment provided 48 hours' notice is given. We reserve the right to assess a $50.00 per half-hour fee for any appointment that is missed without a courtesy call to reschedule. The missed appointment fee is not a covered expense of your insurance company.

Returned Checks: A $35.00 fee will be assessed for any check returned for insufficient funds.

Accounts: A late fee of $35.00 may be assessed to accounts with balances outstanding for 60 days from treatment date. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees etc.

I have read, understand, and agree with all the terms and conditions of this Patient Financial Policy. By signing below I authorize the insurance company to pay Jeffrey Chung DDS all insurance benefits otherwise payable to me for services rendered. I authorize Jeffrey Chung DDS to release all information necessary to secure payment for benefits. I understand that I am financially responsible for all charges.

Signature of Patient/Parent/Guardian____Date_________________________

Serenity Dental

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, ______________________________________, have received a copy of this office's Notice of Practices.

___

Please Print Name

___

Signature

___

Date

___

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as requested by law, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

____

____

____

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $50.00 charge for not showing up for scheduled appointments. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I understand and acknowledge the cancellation policy.

Signature ________________________________ **Date** ____________________