

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Male Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Questions

List any medications you are taking including nonprescription drugs:

Do you have any disease/problem you think we should know about? YES No

Are you allergic to any medications? YES No If yes, please list below:

Have you had a transplant operation that has depressed your immune system? YES No

Are you in good health? YES No

Have you had an allergic reaction to Bananas? YES No

Date of last medical exam: _____

Do you smoke or chew tobacco? YES No

Have you ever been hospitalized? YES No If yes, what was the problem

Have you had Heart Surgery? YES No

Are you now under the care of an MD? YES No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) YES No

FOR WOMEN ONLY:

Are you taking birth control pills? YES No

Are you nursing/breastfeeding? YES No

Are you pregnant? YES No

Expected delivery date: _____

Is there a possibility of pregnancy? YES No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dental History Information

Date of last dental visit? _____

Do you snore? YES No

Name of your previous dentist _____

Do you have problems with bad breath? YES No

Reason for today's visit? _____

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? YES No

Have you ever had an oral cancer screening? YES No

Have you ever used an electric toothbrush? YES No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? YES No

Do your gums bleed when you brush? YES No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Have you or a family member ever been treated for periodontal disease? YES No

Have you ever had complications from an extraction? YES No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew? YES No

- Whiter
- Straighter
- Close space
- replace black mercury filling with tooth colored restorations
- repair chipped teeth
- replace missing teeth
- less gums showing
- replace old crowns or caps that don't match

Are you prone to frequent headaches? YES No

Do you grind or clench your teeth? YES No

Do you have sores, blisters or swelling on your gums lips or cheeks? YES No

Have you ever had orthodontic treatment? YES No

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Dr. Signature: _____

Date: _____

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (If patient is a minor): _____ Date: _____

Bridlewood Dental Office Financial Policy

Dr. Yong C. Song is committed to providing you with the best possible care, and we are pleased to discuss our professional fees at the time service is provided. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility. For your convenience, we accept cash, personal checks and major credit cards. We offer 12 month's interest free payments through Care Credit. We are able to submit an application for you when you come in for the initial visit. You can also apply on line directly with Care Credit @ www.carecredit.com

Dental Insurance Holders

Dr. Yong C. Song provides insurance company billing as a courtesy to our patients. State Law requires us to collect any deductible and Co-Insurance that is due from the patient at the time services are provided. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. **I also understand that if the Practice cannot verify insurance benefits eligibility for me to treatment that I will pay in full for the services at the time they are rendered. It is my responsible for monitoring any amount and/nor the patient may not rely upon any information provided by staff regarding his/her remaining benefit in any such benefit period.** The claims we submit to insurance companies indicate that you have assigned those benefits to Bridlewood Dental. However, if you are paid by the dental insurance company instead of Bridlewood Dental, you then become responsible for the total account balance and payment would be expected immediately, you as a patient are always responsible for any charges that are **not covered** by your insurance. We would like to take the time to thank you for trusting us with your dental health!

Authorization to Treat:

I authorize Dr. Yong C. Song and/or his Associates to treat my dental needs using restorative and/or surgical techniques that are reasonable and necessary as the dentist/hygienist deems advisable. I understand that the treatment plans presented along with the fee outlined could subject to change.

Assignment of Benefits:

I certify that I/Family member is covered by my dental insurance with _____ and assigned directly to Dr. Yong C. Song all insurances benefits, if any otherwise payable to me for services rendered. 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.

The above-named doctor may use my minor child/family member's health care information and may disclose such information to the above-named Insurance Company (ices) and their agents for the purpose of obtaining payment for the services and determining Insurance benefits or the benefits payable for related services.

- **Practice may charge: an amount of \$35.00 permitted by law for each returned check. This consent will end when the current treatment plan is completed or one year from the date signed below.**
- **Delinquent Payments: It is our policy to charge 1.5% for outstanding patient balances after 30 days.**
- **Missed Appointments: Our office will reserve Dr. Song's time only for you. Unless within 48 hours in advanced, our policy is to charge for missed appointments \$50.00.**

Release:

I understand and agree that I am responsible for all charges pertaining to my dental care, regardless of my insurance status. I have read the Financial Policy above and completed the patient registration form. This information is true and correct to best of my knowledge. I am responsible for notifying you of any changes.

Responsible Party Signature _____ Date _____

Yong C. Song DDS, PA

Bridlewood Dental

Discloser of Health Information & Acknowledgement of Notice of Privacy Practices

Purpose of this Consent: (Please read the following statement carefully.)

By signing this form, you will consent for our use of discloser of your protected health information to carry out treatment, payment activities, and health operations.

I hereby assign by benefits contractually to Bridlewood Dental

I authorize release of my information to all insurance carriers

I authorize payment directly to my doctor

I permit a copy of the authorization to be used in place of the original

I hereby certify that I don't have any other insurance coverage

Notice of Private Practice:

You have the right to read the Notice of Private Practice before you decide whether to sign this consent. Our notice describes our treatment, payment activities, and healthcare operations of the uses of disclosers we may make of your protected health information. A copy of our notice accompanies this Consent and is posted in the reception area. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our private practices as described in our Notice of Private Practices. In that event, we will issue a revised Notice of Private Practices which will contain the changes. Those changes will apply to all your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving written notice. Please understand that revocation of your consent will not affect any action we took before we received your revocation.

I had the opportunity to read and consider the contents of this Consent form and Notice of Private Practices. I understand that by signing, I am giving my consent to your use and discloser of my protected health information to carry out treatment, payment activities, and healthcare operations.

Revocation of Consent:

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written notice Revocation. I also understand that you may decline to treat or continue to treat after I have revoked this Consent.

Patient/Relative HIPAA Consent:

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 {HIPAA} requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of the HIPAA requirements, Bridlewood Dental is providing you with a copy of our Notice of Privacy Practices.

I understand that by signing the Consent form, I am giving consent to Bridlewood Dental to discuss and disclose protected health information to carry out treatment, payment activities, and health care operations with the following member.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Right to Revoke: You have the right to revoke this consent at anytime by written notice of your revocation.

Patient Consent & Acknowledgement

Please sign this form Acknowledgement and Consent to our discloser of your information that we deem necessary in order to provide you with proper treatment. I consent to your discloser of my information, which you deem are necessary in connection with my treatment. Communication with laboratories or other specialists for any medical treatment, consultations, and educational purposes or for any purpose deemed appropriate by Bridlewood Dental.

Name (Please print) _____

Signature: _____
(Patient or Parent/Guardian)

Date: _____