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	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

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

_____

_____

Are you in good health? ❑ YES ❑ No

Date of last medical exam: _____

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

_____

_____

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

_____

_____

_____

_____

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

Have you had an allergic reaction to Bananas? ❑ YES ❑ No

Do you smoke or chew tobacco? ❑ YES ❑ No

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? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ YES ❑ No

How often do you floss your teeth? _____

Dr. Signature: _____

Do your gums bleed when you brush? ❑ YES ❑ No

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

Have you ever had complications from an extraction? ❑ YES ❑ No

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

Are you prone to frequent headaches? ❑ YES ❑ No

Do you grind or clench your teeth? ❑ YES ❑ No

Date: _____

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

Have you ever had orthodontic treatment? ❑ YES ❑ No

Do you snore? ❑ YES ❑ No

Do you have problems with bad breath? ❑ YES ❑ No

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

Have you ever used an electric toothbrush? ❑ YES ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ 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

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

- ❑ 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

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.

Reviewed by: _____

Patient: _____ Date: _____

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

Dr. Yong C. Song DDS, PA

Bridlewood Dental

Discloser of Health Information & Acknowledgement of Notice of Privacy Practices

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

By signing this form, you will consent for our used of discloser of your protected health information to carry out treatment, payment activities, and health operations.
I herby 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 placed of the original
I herby certified 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 or 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 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 HIPPA 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: _____ ***Date:*** _____
(Patient or Parent/Guardian)

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 deductable 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. Young 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.***
- ***Miss Appointments:*** ***Our office will reserve Dr. Song's time only for you. Unless within 24 hours in advanced, our policy is to charge for missed appointments $40.00.***

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 _____