# Patient, Pharmacy, and Insurance Information

## Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Social Security # _____

Date of Birth: _____ ☐ ☐ Gender: ☐ Female Male Other: _____

Marital Status: ☐ Single ☐ Married ☐ Child

Primary Language: ☐ English ☐ Mandarin ☐ Japanese ☐ Other: _____

### Address:

Home Address: _____

City: _____ State: _____ Zip Code: _____

### Contact Information:

Home Phone: _____

Mobile Phone: _____

Is it okay if we text you appointment reminders? ☐ Yes ☐ No

Email: _____

Is it okay if we email you appointment reminders? ☐ Yes ☐ No

Does the patient have an Emergency Contact? ☐ Yes ☐ No

Emergency Contact Name: _____ Emergency Contact Number: _____

## Medical History

Does any of the following conditions apply to the patient? This information is needed in order to keep the patient healthy and safe.

☐ No Condition ☐ Lung or Breathing ☐ Digestive or Dietary ☐ Neurological

☐ Autoimmune ☐ Heart or Circulatory ☐ Other Conditions: _____

Is the patient currently taking any medication(s)?

☐ No Medication ☐ Diabetes, Cholesterol, Blood Pressure, Or Metabolic ☐ Allergy, Asthma, or Breathing

☐ Antibiotics ☐ Antidepressants, Anxiety, or _____ ☐ Behavioral ☐ Painkillers Other:

Does the patient have any Allergies? ☐ Yes ☐ No

Does the patient use any Recreational Drugs? ☐ Yes ☐ No

### Medical History Continuation….

Does the patient smoke? ☐ Yes ☐ No

If yes, approximately how much per day: _____

Does the patient have a Primary Care Physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Number: _____

Are there any developmental disorders? (mental and/or physical) ☐ Yes ☐ No

Were there any complications during birth (e.g. preterm birth) or problems with physical growth? ☐ Yes ☐ No

What is the preferred Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

If there are any comments or additional information regarding the patient's medical history, please write it down in the space provided below:

## Dental History

Why is the patient changing their dentist?

☐ Change of Residence ☐ Change of Insurance ☐ I am unhappy with my current dentist

☐ My previous dentist retired or closed ☐ It was too expensive ☐ Your office is closer

☐ You were recommended ☐ I do not have a previous dentist ☐ Other: _____

What is the reason for the patient's appointment?

☐ Exam ☐ Cleaning ☐ Pain ☐ Cosmetic ☐ Second Opinion or Consultation

☐ Other: _____

Is there any additional information you would like to provide relating to your appointment? If so, please write down in the space provided below:

How long has it been since the patient's last dentist appointment?

☐ Less than a month ☐ A month ☐ Three months ☐ Six months ☐ One year

☐ Two years ☐ Three or more years ☐ I haven't been to a dentist before

What would you like to change:

☐ The position or alignment of my teeth ☐ The color of my teeth ☐ Gaps in my teeth

☐ The shape of my teeth ☐ Gummy smile ☐ Other: _____

Does the patient play any sport? ☐ Yes ☐ No

Has the patient ever had any previous bad experience at a ☐ ☐ dentist? Yes No

Has the patient ever had a bad reaction to dental anesthetic? ☐ Yes ☐ No

Has the patient ever had complications following dental work in the past? ☐ Yes ☐ No

If yes, please explain: _____

Are the patient's teeth sensitive to hot or cold? ☐ Yes ☐ No

Do the patient's gum bleed when brushed or flossed? ☐ Yes ☐ No

**Dental History Continuation….**

Are you aware of any sore or irritated areas of the patient's mouth? ☐ Yes ☐ No

Did the patient ever have a sucking habit (pacifier, finger, thumb) after one year of age? ☐ Yes ☐ No

Is there a family history of cavities? ☐ Yes ☐ No

Is there frequent snacking between meals? ☐ Yes ☐ No

Does the patient grind their teeth? ☐ Yes ☐ No

Has the patient ever been diagnosed with periodontal disease? ☐ Yes ☐ No

How often does the patient brush: _____

How often does the patient floss: _____

Do you like your smile? ☐ Yes ☐ No

Are you interested in knowing more about any of the following:

☐ Teeth whitening ☐ Replacing missing teeth ☐ Straightening teeth ☐ White filling ☐ Home care

☐ Gummy smile correction ☐ Breath control ☐ Other: _____

Does the dentist make you anxious or nervous?

☐ Yes, extremely ☐ Yes, moderately ☐ Yes, somewhat ☐ No

If yes, is there anything we can do to help reduce it?

_____

We want your experience to be exceptional. Is there anything you would like us to know beforehand? If there is, then please let us know in the space provided down below:

## Women Patients Only

Is the patient currently pregnant? ☐ Yes ☐ No

If yes, Estimated Delivery Date: _____

Is the patient currently breastfeeding/nursing? ☐ Yes ☐ No

Is the patient currently taking any birth control prescriptions? ☐ Yes ☐ No

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

## Dental Insurance:

Does the patient have dental ☐ ☐ insurance? Yes No

### Primary Dental Insurance:

Is the subscriber the same as the ☐ ☐ patient? Yes No

**Subscriber Information:**

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____

Patient Relationship to Subscriber: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Disabled Dependent ☐ Other Dependent: _____

Subscriber SSN: _____

### Secondary Dental Insurance:

Is the subscriber the same as the ☐ ☐ patient? Yes No

**Subscriber Information:**

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____

Patient Relationship to Subscriber: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Disabled Dependent ☐ Other Dependent: _____

Subscriber SSN: _____

# Office Policy

**Financial Policy**

**Accepted Payment Types**

We accept cash, checks and most major credit cards. We ask for cooperation from all our patients to pay for services the day of treatment, including those with dental insurance. By paying for treatment on the day of service, or the estimated patient portion, it helps us to reduce bookkeeping and billing expenses that increase the cost of your care.

**Cash, Check, or Credit Card Patients**

We ask that all single day services be paid on the day of service. This includes the patient portion for those with dental insurance.

**Insurance Patients**

The patient or guarantor is ultimately responsible for all account balances regardless of insurance coverage. Not all services are covered benefits in all contracts. Your employer has selected the level of coverage based on the premium paid. We submit insurance claims as a patient courtesy, however that contract exists between the patient/insured and the insurance company. We try to help all patients receive the maximum benefits their plans will allow for the treatment they need. When or if there are insurance difficulties, please know that we are working on your behalf and we pledge to do our best. In most cases you have authorized insurance payments to come directly to us. We will estimate your portion based on historical information from your insurance company. Your portion is due the day of service. Please be prepared to pay your estimated patient portion. The Payment is your responsibility at the time of service. To speed up insurance processing, it is important that you are familiar with your insurance coverage and provide us with accurate information. Please provide current dental insurance information with you. This is your responsibility.

**Minor Patients**- The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless payment is prearranged.

**All patients with an outstanding balance** will receive a statement each month. There is a monthly finance charge of 1.5 % (18% APR) on all accounts greater than 60 days overdue. If you pay by check and it does not clear the bank, you will be charged a return check fee of $50.00 per check.

**Office Policy**

**Late Arrival**

We understand that some patients travel long distances to get to the clinic, and in some cases being late for appointments can be unavoidable. Patients arriving more than 15 minutes late for a Dentist, or Hygienist appointment may be requested to reschedule their appointment as it would be difficult to fit their appointment in without the dentist or hygienist running late for other patients.

**Broken Appointments**

In the event of repeated broken appointments or short notice cancellations (less the 48 hours). We may require a $50 charge to reschedule. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, as well as any finance charges, collection costs, or multiple rebilling charges. I have read the financial policy for this office and understand my obligations. I authorize release of any information relating to any claim. I authorize payment directly to Ai Family Dental for benefits otherwise payable to me. I leave my signature on file for future claims that relate to me.

Guardian's Signature:

## Acknowledgement of Receipt of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health- related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are,

however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (tollfree)

Guardian's Signature:

## General Informed Consent

**Examinations and x-rays**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

**Drugs, medication, and sedation**

I understand that antibiotic, analgesics, and other medications can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle

or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

**Changes in treatment**

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on teeth, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make these changes as necessary.

**Temporomandibular joint dysfunctions**

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, that I will be referred to a specialist for treatment,  the cost of which is my responsibility.

With any dental treatment, there is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues. The resulting numbness that could potentially occur is usually temporary, but in rare instances it could be permanent. I understand that every reasonable effort will be made to ensure that any condition is treated appropriately. No guarantee or assurance has been given to me by anyone that any proposed treatment or surgery will cure or improve any conditions.

Guardian's Signature: