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 lonimin, Adipex, Fastin (brand names of phentermine), Pondomin (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		Herpes	Y/N	Stroke	Y/N
extractions or surgery	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	Y/N
Congenital Heart Lesions	Y/N	Mitral Valve Prolapse	Y/N	neck	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)

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Tressa Howe

Telephone:	281-305-8835
Fax:	281-259-2805
Address:	6519 FM 1488, Ste. 505 Magnolia, TX 77354

Serenity Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy 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 required by law, but acknowledgement 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:

_____

_____

_____

Missed Appointment Agreement

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. **We Do Not except cancellations on our voicemail.**

I have read, understand, and agree with all the terms and conditions of Missed Appointment Agreement. By signing below I authorize Jeffrey Chung DDS and/or his staff to assess the above charge should I default on the above agreement. I understand that I am financially responsible for all charges.

_____

Signature of Patient/Parent/Guardian Date

Patient Financial Agreement

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 to be provided. To assist us in achieving these goals, we ask that you review our 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.

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 company 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.

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_____