

# 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                        | Pain around ear         |
| Bleeding gums                     | Periodontal treatment   |
| Blisters on lips or mouth         | Sensitivity to cold     |
| Burning sensation on tongue       | Sensitivity to heat     |
| Chew on one side of mouth         | Sensitivity to sweets   |
| Clicking or popping jaw           | Sensitivity when biting |
| Dry Mouth                         |                         |
| Fingernail biting                 |                         |
| Food collection between the teeth |                         |
| Grinding teeth                    |                         |
| Gums swollen or tender            | How often do you floss? |
| Jaw pain or tiredness             | _____                   |
| Lip or cheek biting               |                         |
| Loose teeth or broken fillings    | How often do you brush  |
| Mouth breathing                   | _____                   |
| Mouth pain, brushing              |                         |
| Orthodontic treatment             |                         |
| Sores or growth in your mouth     |                         |

# 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
Blood Disease	Y/N	High Blood Pressure	Y/N	Swollen Feet or Ankles	Y/N
Cancer	Y/N	Jaundice	Y/N	Swollen Neck Glands	Y/N
Chemical Dependency	Y/N	Jaw Pain	Y/N	Thyroid Problems	Y/N
Chemotherapy	Y/N	Kidney Disease	Y/N	Tonsillitis	Y/N
Circulatory Problems	Y/N	Liver Disease	Y/N	Tuberculosis	Y/N
Congenital Heart Lesions	Y/N	Low Blood Pressure	Y/N	Tumor or growth on head or neck	Y/N
Cortisone Treatments	Y/N	Mitral Valve Prolapse	Y/N	Ulcer	Y/N
Cough, persistent or bloody	Y/N	Nervous Problems	Y/N	Venereal Disease	Y/N
Diabetes	Y/N	Pacemaker	Y/N	Weight Loss, Unexplained	Y/N
Emphysema	Y/N	Psychiatric Care	Y/N	Any history of smoking	Y/N
		Radiation Treatment	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

## ALLERGIES

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

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

- 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 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 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.

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Please Print Name

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Signature

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Date

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#### For Office Use Only

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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):

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## **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** \_\_\_\_\_