CENTRAL DENTISTRY

Dr. Tae Y. Lee & Associates

PATIENT INFORMATION

Name

_____ _____

Last ***First***

Date of Birth _____

Male ☐ Female ☐

Address

_____

_____

(H) phone _____

(C) phone _____

(W) phone _____

Please circle the best number for contact.

Email Address _____

Patients or Parent's Employer

_____

(W) phone _____

If patient is minor, parent or guardian's name

_____

Person to contact in case of an emergency

_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____,

acknowledge that I have read or received a Notice of Privacy Practice from the above named practice.

* Payment of Service is due at the time of treatment.
* There will be $50.00 broken appointment charge without 24 hour notice.

Signature

_____

Patient or Guardian

Date _____

- Which other family members are patient at this office?

_____

_____

_____

How did you hear about our office?

Friend ☐

Insurance ☐

TV/Newspaper Ad ☐

Other _____

PATIENT MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERREALATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Patient's Name _____ **Date of Birth**_____

	Y	N
1. ARE YOU IN GOOD HEALTH	☐	☐
2. PHYSICIAN'S NAME _____		
PHONE NO. _____		
3. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN.....	☐	☐
4. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICATION.....	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING_____		
_____		
5. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	Y	N
LOCAL ANESTHETICS LIKE NOVOCAINE.....	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS.....	☐	☐
SULFA DRUGS.....	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS.....	☐	☐
ASPIRIN.....	☐	☐
IODINE.....	☐	☐
LATEX / RUBBER.....	☐	☐
ANY METALS (EG, NICKEL, MERCURY AND ETC.).....	☐	☐

OTHER (PLEASE LIST) _____

_____

_____

_____

_____

_____

_____

	Y	N
6. HAVE YOU HAD ANY BLEEDING PROBLEM.....	☐	☐
7. DO YOU BRUISE EASILY.....	☐	☐
8. Have you ever taken Osteoporosis medicine.....	☐	☐

WOMEN ONLY

	Y	N
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT.....	☐	☐
ARE YOU NURSING.....	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS.....	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	Y	N
HEART DEFECT OR HEART MURMUR.....	☐	☐
HEART TROUBLE, HEART ATTACK. OR ANGINA.....	☐	☐
CHEST PAIN.....	☐	☐
SCARLET FEVER.....	☐	☐
PACEMAKER.....	☐	☐
HEART SURGERY.....	☐	☐
CONGENITAL HEART PROBLEM.....	☐	☐
STROKE.....	☐	☐
SINUS TROUBLE.....	☐	☐
HEPATITIS, OR LIVER DISEASE.....	☐	☐
LUNG OR BREATHING PROBLEMS.....	☐	☐
HIVES OR SKIN RASH.....	☐	☐
FAINTING OR DIZZY SPELLS.....	☐	☐
DIABETES.....	☐	☐
AIDS OR HIV INFECTION.....	☐	☐
TUBERCULOSIS.....	☐	☐
JOINT REPLACEMENT OR IMPLANT.....	☐	☐
SEXUALLY TRANSMITTED DISEASE.....	☐	☐
EPILEPSY OR SEIZURES.....	☐	☐
MENTAL HEALTH CARE.....	☐	☐
MITRAL VALVE PROLAPSE.....	☐	☐
CORTISON TREATMENT.....	☐	☐
THYROID PROBLEMS.....	☐	☐

X_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**

DENTAL INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Company Phone Number: _____

Name of Insured: _____

Birth Date: _____

SS or ID Number: _____

Group Number: _____

Relationship to Patient: _____

Policy Regarding Dental Insurance

Our professional treatment is rendered to you not the insurance company. You are responsible to CENTRAL DENTISTRY for the obligation of payment of treatment.

To serve and assist you in utilizing your dental insurance, this office accepts assignment of your benefits. However, if you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. We are not responsible for determining what those benefits are to be.

We will do our best to see that you receive your full benefits within the structure of your particular dental plan. However, ultimate responsibility for payment is yours and Patient's Co-Pay is due at the time of treatment.

Thank you

_____ _____

Signature of Patient or Guardian Date

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

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you this notice about our privacy practice, our legal duties and your rights concerning your health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. You may request a copy of our notice.

When do we use and disclose of health information?

We use and disclose your health information for treatment, payment, and health care operations.

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

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

Health Care Operations: We may disclose your health information to another health care provider or organization that has a relationship with you to support some of their healthcare operations.

Family /Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

If you are not present or in an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information and notifying your location and general condition.

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

Public Benefit: We may use or disclose your health information as authorized by law for the purposes deemed to be in the public interest or benefit.

You may give us written authorization to use or disclose your health information to anyone for any purpose except those authorized by law. Your authorization and revocation must be done in writing.

What are patient's rights?

Access: You have the right to get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information and if you request copies, we will charge you a reasonable cost-based fee for copies and staff time.

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 those restrictions, but if we do, we will abide by our agreement (except emergency). The agreement must be made in writing and signed by an authorized person.

If you have questions or concerns, please contact our office.