

PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

Are you taking any of these meds? **P Q** [GU] **P Q** [GU]

| | | | | | |
|---|----|-----|-----------------------|-----|-----|
| Pre-medication before dental treatment? | No | Yes | Tagamet (Cimetidine)? | No | Yes |
| Antacids? | No | Yes | Herbal supplements? | No | Yes |
| Have you been treated with Bisphosphonate drugs? | | | No | Yes | |
| Are you currently taking any prescription or non-prescription Anti-Fungal Medication? | | | No | Yes | |

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

P Q [GU]

Are you required to Pre-Medicate before dental treatment ? No Yes
 (Due to heart problems, joint replacement, and rheumatic fever)

Do you have a sleep disorder? (Example: Restless Legs Syndrome, Night Terrors) No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____ Restricted Diet _____ How many meals a day _____

DOCTOR'S USE ONLY FROM HERE TO BOTTOM OF PAGE

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Doctor (Print Name)

Doctor Signature

Date

DOCTORS INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

| | | | | | |
|--------------------------------------|----|-----|-----------------------|----|-----|
| Heart (Surgery, Disease, Attack) | No | Yes | Hepatitis, Any Form | No | Yes |
| Heart Murmur (mitral valve prolapse) | No | Yes | Rheumatic Fever | No | Yes |
| Joint Replacement | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Taken Fen-phen or other diet pills | No | Yes | | | |

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have any allergies? ? No Yes List: _____

Notes: _____

PATIENT DENTAL HISTORY

How important is it that you keep your natural teeth for the rest of your life?

What do you like about your teeth? _____

Is there anything that you don't like about your teeth? _____

Is there anything about your teeth/smile that makes you feel self-conscious or embarrassed?
If yes please explain _____

If we could help you to achieve your ideal smile would you be interested? _____

When thinking of your ideal smile what do you see as your biggest obstacle to getting it?

Do you have any pain in your teeth, gums, jaw/joint or neck? Do you have frequent headaches? If yes explain _____

Do your gums bleed when you brush or floss? _____

Have you ever been told that you have gum disease, periodontal disease, pyorrhea, bone loss or gingivitis? If so which one? _____

Are your teeth sensitive to hot, cold, sweets or biting pressure? If so which one?

Do you have any places where food gets caught or that shreds floss? _____

Do you have a denture, partial or dental implant? _____

Have you ever had any problems with dental procedures in the past? If yes explain.

Do you feel anxious or scared when coming to the dentist? _____

Is there anything else you would like the dentist to know about your dental history?

Signature

Date

JEROME Y. CHA, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

I have also received a copy and understand the **Financial Policy** of this office.

Name (Please Print)

Signature

Date

Please Note: It is your right to refuse to sign this acknowledgement.

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other:

JEROME Y. CHA, DDS

OUR FINANCIAL/CANCELLATION POLICY

All patients are expected to pay their total portion in cash, check or credit card the day the service is rendered. (Sedation visits must be paid in full 2 weeks before appointment).

Appointments: When an appointment is made it is considered a confirmation. Therefore, we do not call to confirm your appointment. Only if you specifically request a courtesy call one will be given. We do not overbook our schedule and the time is reserved **especially for you**. Please let us know at least 48 hours in advance if you need to change the appointment for any reason. This will enable us to offer the time to someone else. Our office reserves the right to charge \$134/hour for appointments cancelled or broken without 48 hours of notice.

Insurance: For those patients covered by insurance, we will file your primary insurance as a courtesy to you. Secondary claims must be filed by you. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be asked to pay your portion the day the service is rendered. If after 45 days the insurance has not paid, you will be required to pay the remaining balance. We will assist you in dealing with the insurance company, but ultimately the responsibility lies with you. **It is your responsibility to know your dental policy.** Often times, the insurance companies will not give us all the information we need or they may give us wrong information. We highly recommend you call your insurance company and ask questions and thoroughly understand your policy. If you have any other questions, feel free to contact us. We wish to be of assistance in any way we can.

Thank you,

Financial coordinator

ALL PATIENTS

PLEASE READ THIS CAREFULLY

By my signature below, I acknowledge that I understand that the amount quoted as my portion (the portion of my bill that insurance does not pay) was based on telephone verification with my insurance company only. I understand that my insurance company does **NOT** view this telephone correspondence as a promise to pay, and thus quoted benefits are an **estimate only**. This means that once the insurance pays the claim, I may have a refund coming, or I may owe additional fees. I understand that sometimes insurance companies say one thing on the phone, and in actuality pay the claim much differently. I understand that I am responsible for any amount not paid by my insurance company, regardless of the estimate I receive in advance as to my portion of the bill. I also acknowledge by my signature below that I have been given the opportunity to ask questions of my doctor's staff concerning billing, and I have had/will have the opportunity to call my own insurance company regarding payment of this claim.

Signature

Date