PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SOC. SEC. NO. _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

_____

_____

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ CHEST PAINS	☐ KIDNEY DISEASES
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ EASILY WINDED	☐ AIDS OR HIV INFECTION
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ STROKE	☐ THYROID PROBLEM
☐ SWOLLEN ANKLES	☐ ANGINA	☐ HAY FEVER / ALLERGIES	☐ HEPATITIS / JAUNDICE
☐ FAINTING / SEIZURES	☐ FREQUENTLY TIRED	☐ TUBERCULOSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ ASTHMA	☐ ANEMIA	☐ RADIATION THERAPY	☐ STOMACH TROUBLES / ULCERS
☐ LOW BLOOD PRESSURE	☐ EMPHYSEMA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ EPILEPSY / CONVULSIONS	☐ CANCER	☐ RECENT WEIGHT LOSS	☐ OTHER _____
☐ LEUKEMIA	☐ ARTHRITIS	☐ LIVER DISEASE	_____
☐ DIABETES	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	_____

COMMENTS

_____

_____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	8. DO YOU HAVE FREQUENT HEADACHES?	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY?	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐
A) CLICKING?	☐	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐		
C) DIFFICULTY IN OPENING OR CLOSING?	☐		
D) DIFFICULTY IN CHEWING?	☐		

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

ACCESS DENTAL CARE
TERRY SONG, D.D.S.
10643 PROFESSIONAL CIRCLE, SUITE102
RENO, NV 89521
(775) 737-4035

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

ACCESS DENTAL CARE

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, MasterCard, CareCredit.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Missed Appointments

Appointment time is reserved exclusively for the scheduled patient. By giving 24 hours' Notice of appointment changes or cancellations, other patients who will need our time and care can be appointed. If 24 hours' notice is not given, a $25.00 charge will be billed to the patient, unless a proof of excuse (for example: Doctor's Note) is provided within 7days of missed appointment date.

Miscellaneous Services

If in the future you should need copies of your records, we do charge a fee of $10 for these services. It takes our office 7 business days in order to process a request so please plan ahead. Non-Sufficient Funds Check Fee is 25.00. I understand and agree to this financial policy. I have read the financial policy and agree that a Photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely Payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Access Dental Care.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Note: A copy of this form shall be as the original.

_____

Patient Name (Please Print)

_____

Responsible Party Name (Please Print)
(if different than patient)

_____

Patient/Responsible Party Signature Date

ACCESS DENTAL CARE

PATIENT CONTACT CONSENT

I consent to Access Dental Care using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time.

My cell phone number is: _____

I consent to receiving email communications from Access Dental Care regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time.

My email address is: _____

Patients Name:_____

Patients Signuture:_____

Date:_____

Thank you for your continued trust!