Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.

PLEASE COMPLETE ALL 5 PAGES

Patient Information

Name _____ Preferred Name: _____ SSN#: ___ - ___ - ____

Last, First Middle or Nickname if any

Address _____

City State Zip

Home Phone _____ Cell Phone _____ Email _____

Sex: □Male □Female Age ____ Birthdate / / □Single □Married □Widowed □Separated □Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Home #: ( ) -

Relation: _____ Cell # ( ) - Work #: ( ) -

Primary Insurance

Person Responsible for Account _____

Last Name First Name M.I

Relation to Patient _____ Birthdate / / SSN#: ___ - ___ - ____

Address (If different from patient) _____

City State Zip

Home Phone _____ Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Subscriber or Member ID # _____ Group# _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional Insurance? □ Yes □ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient) _____ Soc. Sec _____

Cell Phone _____ Email _____

Insurance Company _____ Phone _____

Subscriber or Member ID # _____ Group # _____

Name of other dependents under this plan _____

Patient Medical History

Physician's name _____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? □ Y □ N

If yes, describe _____

Are you currently under physician care? □ Y □ N If yes, describe _____

Women: Are you pregnant? □ Y □ N or Taking birth control pills? □ Y □ N

OBGYN Contact Information: _____

Check Yes or No whether you have had any of the following & Circle all that apply:

□ Y □ N AIDS/HIV Positive	□ Y □ N Anaphylaxis
□ Y □ N Anemia	□ Y □ N Arthritis, Rheumatism
□ Y □ N Artificial heart valves	□ Y □ N Artificial joints When?_____
□ Y □ N Asthma	□ Y □ N Atopic (allergy prone)
□ Y □ N Back problems	□ Y □ N Blood disease
□ Y □ N Blood Transfusion	□ Y □ N Chemical dependency
□ Y □ N Cancer	□ Y □ N Circulatory problems
□ Y □ N Chemotherapy or Radiation	□ Y □ N Cough persistent
□ Y □ N Diabetes	□ Y □ N Drug / Alcohol Abuse
□ Y □ N Epilepsy / Fainting	□ Y □ N Excessive Bleeding
□ Y □ N Food allergies:_____	□ Y □ N Glaucoma
□ Y □ N Frequent Headaches or Migraines	□ Y □ N Heart Problems (murmur, a-fib, coronary, etc.)
□ Y □ N Hemophilia/Abnormal bleeding	Describe _____
□ Y □ N Hepatitis	□ Y □ N Herpes
□ Y □ N Jaw pain or surgery	□ Y □ N High or Low blood pressure (Circle one)
□ Y □ N Liver disease	□ Y □ N Kidney disease or malfunction
□ Y □ N Mitral valve prolapse	□ Y □ N Mental Health Disorders
□ Y □ N Pacemaker or other heart surgery	□ Y □ N Nervousness / Anxiety
□ Y □ N Rapid weight gain or loss (Circle one)	□ Y □ N Psychiatric care
□ Y □ N Respiratory disease	□ Y □ N Cortisone treatments
□ Y □ N Shingles	□ Y □ N Rheumatic or Scarlet fever (Circle one)
□ Y □ N Shortness of breath	□ Y □ N Sinus Problems
□ Y □ N Skin disease	□ Y □ N Stroke When?_____
□ Y □ N Swelling of feet or ankles	□ Y □ N Thyroid disease or malfunction
□ Y □ N Tobacco habit	□ Y □ N Tonsillitis
□ Y □ N Tuberculosis	□ Y □ N Ulcer / Colitis / Tumors (Circle all that apply)
□ Y □ N Venereal disease	□ Y □ N Cholesterol

Is patient currently taking any medications? If yes, list all: _____

_____

Does patient have drug allergies? If yes, list all: _____

_____

Family Medical History

Do any of the patient's family members have any pertinent medical history and/or conditions that may affect the patient's dental care? If so, please indicate below:

_____

_____

Dental History

Former Dentist _____ Phone _____ Date of last cleaning _____

Date of last dental check-up _____ Date of last x-rays _____

Check Yes or No if you have had problems with any of the following:

□ Y □ N Bad breath

□ Y □ N Bleeding gums

□ Y □ N Clicking or popping jaw

□ Y □ N Periodontal treatment

□ Y □ N Sensitivity to sweets

□ Y □ N Sensitivity when biting

□ Y □ N Food Collection between teeth

□ Y □ N Grinding or clenching teeth

□ Y □ N Loose teeth or broken fillings

□ Y □ N Sensitivity to cold

□ Y □ N Sensitivity to hot

□ Y □ N Sores or growths in mouth

How often do you brush? _____ Floss _____

What can we help you with to improve your smile? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □ Y □ N

What is your main concern for today's visit? _____

Is there anything that we can do to make you feel more comfortable today? _____

AUTHORIZATION

Permission is granted for the dentist to perform procedures (including examination, taking radiographs and obtaining a medical and dental history) in order to determine my or my child's dental treatment needs and clinical assignment. I understand that radiographs are an essential tool in evaluating my or my child's treatment needs. I also understand there is a minimal risk associated with exposure to radiation and that all appropriate precautions will be used to keep radiation exposure to a minimum. I understand that I have the right to refuse any procedure. I will be responsible to any negative results, if I refuse treatment against dental advice and refusal may result in termination of my or my child's treatment.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical statues, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered, I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure the payment of benefits, I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ **Date** _____

Co-Pays & Payments are due in full at the time services are rendered.

HIPAA Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day to day healthcare operations of your practice.
- I have also been informed of and given the rights to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these request restrictions.
- However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.

The Patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, or workman's company without your written consent.
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.
- The practice of Dr. Catherine H. Cho reserves the right to change the notice of privacy practices.
- The patient has the right to restrict the use of their information, but the practice of Dr. Catherine H. Cho does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice of Dr. Catherine H. Cho may condition treatment upon the execution of this consent (for example, you may be required to pay your visit at the time of service)

Signature _____ **Date** _____

Relationship to Patient (if minor) _____

Cancellation/Missed Appointment Policy

Our goal is to provide quality dental care in a timely manner. In order to do so, we have had to implement a cancellation/missed appointment policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful & prompt to the needs of all our patients, please be courteous and call Smileworks Dentistry promptly, if you are unable to attend your scheduled appointment time. If it is necessary to cancel your scheduled appointment, we require that you **call at least 24 hours in advance,** and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely dental care. Late cancellations will be considered as a "no-show". A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to dental care in a timely manner. If you fail to be present at the time of a scheduled appointment it will be recorded in the patient's chart as a "no-show". **Failure of canceling your appointment or not showing up will result in a missed appointment fee of $35.00 per hour** billed to your account. If three appointments are missed we reserve the right to dismiss you as a patient. Please note that this missed appointment fee is NOT covered by insurance plans and is your responsibility to pay in full. _____(Initials)

How to Cancel Your Appointment:

To cancel appointments, please call (480) 883-7730. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

If you have any questions, please do no hesitate to ask us. We sincerely appreciate your understanding and cooperation with this matter. Thank you with your assistance in complying with our policy

_____ _____

Patient Signature (if under 18 have legal guardian sign) **Date**