Dr. Paul Jang Dentistry

Health Questionnaire

General Information

How did you hear about us?

□ Mailer □ Yelp □ Google □ Referral: _____ □ Other: _____

Primary purpose of visit:

□Changing Dentists □Cleaning □Long overdue for dental visit

□Pain □Cosmetic (Veneers/Implants □Other: _____

Which of the following qualities are most important to you during your dental visit?

□Honesty □Friendly staff □New and Modern Technology

□Gentle Dentistry □Budget/Finances □Other: _____

What is the level of your dental anxiety or nervousness?

□Mild □Moderate □Severe □Extremely severe

Position:

□Single □ Married □ Divorced □Widowed

Name: _____ _____ _____

Last First (PREFERED NAME IF APPLICAPLE)

Address: _____ _____

Street Apt/unit

_____ _____ _____

City state zip

Birth date: _____/_____/_____ Social Security: _____-_____-_____

Cell phone: (_____) _____-_____ Home phone: (_____) _____-_____

Email: _____ @_____

Occupation_____

Dental Insurance

Person responsible for account (If other than the patient): _____

Employer_____

Insurance company: _____

Insurance Phone Number: _____

Subscriber's name: _____

Subscriber ID or Social Security #_____

Subscribers date of Birth: _____

Subscribers Relationship to patient: _____

Dental Health

Y N

□ □ Pain or discomfort at this time?

□ □ Sensitive or bleeding gums?

□ □ Any type of trauma to your mouth, jaw or face? If yes, describe:

_____

□ □ would you like to change anything about your smile? If yes, describe:

_____

□ □ Are you asked by your medical doctor to pre-medicate before any dental treatment?

□ □ Taken Fen-phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation? _____

Please list all medications you are currently taking (including prescription and OTC) (Example listed below).

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275mg	2x a day	daily
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For Women Only

Y N

□ □ Are you pregnant? If yes, due date: _____

□ □ Are you taking birth control pills?

□ □ Could you be Pregnant?

□ □ Are you nursing?

□ □ Hormone replacement?

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Medical Health

Have you been hospitalized in the last five (5) years? Yes □ No □ If yes, please describe:

_____

Do your smoke or use chewing tobacco □ Yes □ No

Are you allergic or have you reacted adversely to any of the following (check all that apply)?

Y N	**Y N**
□ □ Penicillin	□ □ Latex
□ □ Metal: _____	□ □ Ibuprofen
□ □ Nitrous oxide	□ □ Acetaminophen/ Tylenol
□ □ Antibiotics: _____	□ □ Local anesthesia (Novocain)

Please list any other allergies to include medications you are allergic to:

_____

Check any of the following that you have had or have at the present:

Y N	**Y N**
□ □High/Low blood pressure (**circle one**)	□ □Diabetes Type1/ Diabetes Type2(**Circle one**)
□ □Heart disease or heart surgery	□ □Asthma/ Breathing disorder
□ □Artificial joints/ Heart valves (**Circle One**)	□ □Bleeding disorder
□ □Psychological disorder	□ □Tuberculosis or lung disease
□ □History of drug addiction/ alcoholism	□ □ AIDS or HIV+
□ □Radiation treatment	□ □ Bisphosphonate therapy (for Osteoporosis)
□ □ Hepatitis A/ Hepatitis B (**Circle One**)	□ □Cancer or tumor (**circle one**)
□ □Herps or cold sores	□ □Neurologic conditions
□ □Hay fever or sinus trouble	□ □Epilepsy, seizures or fainting spells
□ □Blood transfusion	□ □Diabetes
□ □Alcoholism	□ □Artificial joint
□ □ Migraines headaches/frequent headaches	□ □ abnormal bleeding
□ □Kidney disease	□ □Pacemaker

Do you have any disease, condition or problem not listed?

_____

_____

Major surgeries:

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Authorization

I have reviewed the information on this form 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 status, I will inform the dentist.

Patients Name (Print): _____

Signed: _____

Date: _____

Paul Jang, D.D.S.
14711 Princeton Ave Ste 12
Moorpark CA 93021
805-529-4821

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require you read, agree to, and sign prior to any treatment.

Please note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and Care Credit. **Also, additional fees will be applied for returned checks, in the amount of $50.00.**

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequencies, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for a detail of your insurance. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filling the claim. If payment is not received, or your claim is denied, you will be responsible for the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. **Unaccompanied Minors**: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or emergency treatment may be declined.

Missed Appointment(s) and cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least 48-hour notice for any cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge ($50.00) may be assessed for multiple missed short notice or cancelled appointment. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient Treatment and Financial Policy was signed by:

_____
Patient name Printed

_____ _____
Patient or Parent' Signature Date

Relationship to the patient (**if other than patient**): _____

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HIPAA Acknowledgement and consent form

Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If it does change, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosure we have already made reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy policies.
- The patient has the right to restrict the uses of their information
- The patient may revoke this consent in writing and at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA consent was signed by:

_____
Patient name Printed

_____ _____
Patient or Parent' Signature Date

Relationship to the patient (**if other than patient**): _____