FAMILY DENTISTRY at BUCKEYE MARKET PLACE

PERSONAL INFORMATION-HEALTH HISTORY

NAME _____**Birth Date:** _____**Gender**:_____**Social Security #**_____

PARENTS NAME (IF PATIENT IS A MINOR)_____Birth Date_____

MAILING ADDRESS_____CITY_____ST_____ZIP_____

E-MAIL ADDRESS_____MARITAL STATUS: Single___Married___Divorced___

PHONE: HOME_____WORK_____CELL_____

Does patient have dental insurance? _____ Name of Insurance Co._____

Subscriber Name: _____ Birth Date: _____ Employer:_____ ID#_____

Does patient have Dual Coverage? _____ Name of Insurance Co._____

Subscriber Name: _____ Birth Date: _____Employer:_____ ID#_____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME_____

Mailing Address_____ Daytime Phone_____

HEALTH HISTORY (please circle if you **HAVE** or **HAD** any of the following**.)**

YES	NO	Are you in good Health?	YES	NO	Diabetes_____
YES	NO	TB, Asthma or Lung disease_____	YES	NO	Thyroid disorder_____
YES	NO	Chest pain, shortness of breath_____	YES	NO	Tumors, Cancer, Radiation treatment_____
YES	NO	Bleeding problems, bruise easily_____	YES	NO	Kidney or Bladder disease_____
YES	NO	Stroke_____	YES	NO	Psychiatric care_____
YES	NO	Blood Thinner or Aspirin_____	YES	NO	Headaches, ringing in ears_____
YES	NO	Fainting or Seizures_____	YES	NO	Pregnant: Months_____
YES	NO	Heart murmur, Rheumatic fever_____	YES	NO	Birth control pills_____
YES	NO	Heart valve defect, Heart disease_____	YES	NO	Hip, Knee or Joint Replacement, Year_____
YES	NO	Pacemaker_____	YES	NO	Joint pain or stiffness, arthritis_____
YES	NO	High Blood Pressure_____	YES	NO	Has your Health changed in the last year___
YES	NO	Hepatitis or Liver disease_____	YES	NO	Advised to pre-medicate for dental work___
YES	NO	HIV, AIDS, ARC_____	YES	NO	Any Conditions not listed above_____

List any and all **ALLERGIES:** _____

List any and all **DRUGS/MEDICATIONS** you are taking: _____

_____

List any and all **SURGERIES**_____

List any ill effects from **Novocain, Penicillin** or any other drug: _____

Have you ever experienced any unfavorable reaction from previous **Dental Treatment?** _____

YES **NO** Are you being treated by a **Physician** now? Who? _____

The above Information is true and correct to the best of my Knowledge:

PATIENT OR GUARDIAN SIGNATURE_____**DATE:**_____

OCR NOTICE OF NONDISCRIMINATION

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-623-386-3333

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-623-386-3333

FAMILY DENTISTRY at BUCKEYE MARKET PLACE
Kyong (Steve) Yi, D.M.D. & Associates

GETTING TO KNOW YOU

Name _____**Date:** _____

What name would you like us to call you? _____

How did you hear about our office? _____

Please describe the reason for your visit today:

_____

_____

When was your last dental check up? _____

What are your priorities or concerns and what would you like to see done now?

_____

_____

Have you noticed or has any dentist or hygienist ever said that you:

YES	NO	Have gum disease	YES	NO	Lip or cheek biting
YES	NO	Grind your teeth	YES	NO	Loose or broken teeth or fillings
YES	NO	Clicking or popping jaw	YES	NO	Food collection between teeth
YES	NO	Jaw Pain or tiredness	YES	NO	Sores, blisters or growths
YES	NO	Pain around ear	YES	NO	Bad Breath

Sensitive to: □ **cold** □ **heat** □ **sweets** □ **biting or chewing** □ **gum tenderness or pain**

1300 S. Watson Rd, Suite A-1OO • Buckeye, AZ 85326 • **623.386.3333**
www.familydentistryofbuckeye.com

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under *the Health Insurance Portability & Accountability Act* of 1996 (*HIPAA*). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a member of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used and/or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

We do make reminder phone calls, send e-mail and text messages on certain occasions. If for any reason you choose not to have us use these manners, please inform us in writing.

Patient Name: _____ Date:_____
Signature: _____
Relationship to Patient:_____

Do you authorize our office to discuss any of your dental health needs or conditions with another person? _____ If so, who do you authorize us to speak to?_____

For Office Use Only:

We were unable to obtain the patients written acknowledgement of the *Notice of Privacy Protection* due to the following reasons:

- ☐ The patient refused to sign the form.
- ☐ Communication barriers.
- ☐ Emergency situation.
- ☐ Other:_____

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FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. Your clear understanding of our financial and privacy policies is important to our professional relationship.

- Payment is due at the time of service, including co-pay.
- **A (24) hour notice is needed to reschedule an appointment. If a (24) hour notice is not given…a $50.00 service fee will be charged to your account.**
- If insurance is involved, co-pay and any deductible needs to be paid at the time services are rendered.
- If your insurance company denies payment for any reason, you will be responsible for the entire bill.
- We will accept Cash, Check, MasterCard, Visa, Discover, American Express and Care Credit

It is the patient's responsibility to pay the remaining balance that is not covered by the dental or insurance plans.

If care is being rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the balance on the account.

All treatment plans are estimates only based on information given to us by your insurance company. Any differences between the estimate and what your insurance company pays are your responsibility. Fees are good for (6) months from the date treatment is planned and after that time are subject to change. Posterior composites may not be covered at the same percentage as silver fillings. Signing this does not obligate you to have treatment; it only acknowledges that you received this information.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay on my behalf.

_____ _____

Date Signature

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AUTHORIZATION FOR SIGNATURE ON FILE

Release of information/Financial Responsibility/Authorization for Payment

I,_____ and/or _____
Name of Patient (Parent/Guardian if Minor) Name of insured

hereby authorize the office of Kyong Yi, DMD, to affix my name to any and all dental insurance claims or documents as related to any and all health benefits due me and my dependents.

I hereby authorize payment of dental benefits, otherwise payable to me directly, to the office. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan or insurance plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date. A photocopy of this document may act as the original

_____
Signature of Insured

_____ _____
Signature of Patient (Parent or Guardian if Minor) Today's Date

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