PATIENT INFORMATION

Has any member of your family been a patient of our office? Yes / No Name of Siblings:_____

Date:_____ _____

Patient Name:_____ Patient **Social Security** #:_____

Address:_____ Tel (C):_____

City:_____ State: _____ Zip: _____ Tel (H):_____

Birthday: _____/_____/_____/ Age:_____ Sex: Male/Female

Parent Employed By:_____ **E-Mail**:_____

Business Address:_____

City:_____ State: _____ Zip: _____ Tel:_____

Who is responsible for this account?_____ Relationship to Patient: _____

Who should we contact in an emergency?_____ Phone:_____

DENTAL INSURANCE INFORMATION

Dental Insurance Primary Carrier	**Dental Insurance Secondary Carrier**
Insured's Name: Social Security #:	Insured's Name: Social Security #:
Insurance Company:	Insurance Company:
Address:	Address:
Group Number: ID Number: Birthday:	Group Number: ID Number: Birthday:
Insured's Employer:	Insured's Employer:

What problems would you like to discuss with the doctor and how may we help you?_____

_____

How did you hear of our office?_____

CHARGES AND PAYMENTS: Charges will be explained and agreed prior to dental treatment. Payment is payable **at the time services** are rendered. There is a **charge for broken appointments**. Failure to keep a reservation and/or failure to give the office more than a 24 hour working day notice of cancellation will constitute a broken appointment.

Thank you for your cooperation and for selecting our dental office. We will do our best to make your visits as caring as possible.

MEDICAL HISTORY

1. When were your teeth cleaned last?_____(month/year) 1b. Have taken BISPHOSPHONATES? YES NO
2. Are you having pain or discomfort at this time? YES NO
3. Do you feel very nervous about having dental treatment? YES NO
4. Have you ever had a bad experience in a dental office? YES NO
5. Have you been a patient in the hospital during the past two years? YES NO
6. Have you been under the care of medical doctor during the past two years for other than routine exams, and if so, why? YES NO
7. Are you taking any medicine or drugs? (if so, name) YES NO
8. Are you allergic to (i.e.., itching, rash, swelling, of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any other drugs or medications? , and if so, List? YES NO
9. Have you ever had any excessive bleeding requiring special treatment? YES NO
10. Have you ever had any of the medical conditions listed below? **Please answer each Yes or No.**

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Failure	☐	☐	Stroke	☐	☐	Chemotherapy	☐	☐	AIDS
☐	☐	Heart Disease/Attack	☐	☐	Kidney Trouble	☐	☐	Liver Disease	☐	☐	Hepatitis A (Infectious)
☐	☐	Angina Pectoris	☐	☐	Ulcers	☐	☐	Rthritis	☐	☐	Hepatitis B (Serum)
☐	☐	High Blood Pressure	☐	☐	Emphysema	☐	☐	Rheumatism	☐	☐	HIV+
☐	☐	Heart murmur	☐	☐	Cronic Cough	☐	☐	Cortisone Medicine	☐	☐	Yellow Jaundice
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis (TB)	☐	☐	Glaucoma	☐	☐	Blood Transfusion
☐	☐	Congenital Heart Lesions	☐	☐	Asthma	☐	☐	Pain in Jaw Joints	☐	☐	Drug Addiction
☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐	Epilepsy or Seizures	☐	☐	Hemophilia
☐	☐	Artificial Heart Valve	☐	☐	Sinus Trouble	☐	☐	Fainting or Dizzy Spells	☐	☐	Syphilis
☐	☐	Heart pacemaker	☐	☐	Allergies or Hives	☐	☐	Sickle Cell Disease	☐	☐	Gonorrhea
☐	☐	Heart/Bypass Surgery	☐	☐	Diabetes	☐	☐	Bruise Easily	☐	☐	Cold Sores
☐	☐	Artificial Joint	☐	☐	Thyroid Disease	☐	☐	Periodontal Disease	☐	☐	Genital Herpes
☐	☐	Anemia	☐	☐	X-ray/Cobalt Treatment	☐	☐	Other	☐	☐	Psychiatric Treatment

11. Physician's Name:_____ Telephone:_____
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
13. Do your ankles swell during the day? YES NO
14. Has your medical doctor ever said you have cancer or a tumor? YES NO
15. Do you have any disease, condition, or problem not listed? YES NO
16. Do you smoke? If so, how much?_____ YES NO
17. WOMEN: Are you pregnant now? YES NO
    Are you taking birth control pills? YES NO

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. If I ever have any changes in my health, or if my medicines change, I will inform the Doctor of Dentistry at my next appointment without fail. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits other wise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent of minor Date Dentist's Signature Date

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Patient Signature	Dr. Signature

MY HOME DENTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIAL FACT SHEET

SECTION A: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy BEFORE YOU DECIDE WHETHER TO SIGN THIS Consent . Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Min C. Do, DDS
Telephone: 213-384-2121 or 714-994-2121

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Address: 3663 W. 6th St. #303, Los Angeles, CA 90020 or 5661 Beach Blvd #100, Buena Park, CA 90621

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/DENTAL MATERIAL FACT SHEET

I have received a copy of this office's Notice of Privacy Practices and Dental Material Fact Sheet (dated Oct. 2001)

I have had full opportunity to read and consider the contents of this Consent form, your Notice of Privacy Practices and dental material fact sheet. I understand that by signing this Consent from, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care questions.

Name (Print):_____

Signature:_____Date_____

If this Consent signed by a personal representive on behalf of the patient complete the following:

Personal Representive's Name:_____

Relationship to Patient:_____

YOUR ARE ENTILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.