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

DENTAL HISTORY

1. Child's Name:
2. Reason for today's visit:
3. Former Dentist 4. City, State
5. Date or Last dental visit
6. Has your child had an unfavorable experience in a previous dental(medical) office?
7. Have there been any injuries to your child's teeth or jaws - fails, blows, chips, etc.?
8. Does your child receive fluoride vitamins, tablets, water, etc.?
9. Has an orthodontist seen your child? If so, Who?

CHILD'S HABITS

10. Does your child:

Suck his / her Thumb / Finger / Lips YES NO
Bite / Chew his / her nails or hard objects YES NO
Grind his / her teeth YES NO

MEDICAL HISTORY

11. Physician's Name: Date of last visit: Phone #:

12. Is your child currently under the care of a physician for any medical problem or condition? YES NO

If YES, please describe

13. Is your child currently taking any medicine / allergic to any medication ? YES NO

Please list name and dosage

14a. Has child taken any weight loss medications? (e.g. PenFen) YES NO

14b. Has child taken BISPHOSPHONATES? YES NO

15. Has your child ever been hospitalized or had surgery? YES NO

Please describe(for what condition and when)

16. Has your child ever had any of the following? (Please circle if yes)

Asthma
Cancer
Hepatitis
Hemophilia / Blood Disorder
Rheumatic Fever
Allergies
Epilepsy or Seizures
Tuberculosis
ADD / ADHC
Liver Disorder
Kidney Disorder
Gastrointestinal Disorder
Diabetes
Congenital Heart Defect
Heart Murmur
Anemia
Red Dye Allergy
Latex Allergy

* Was your child born prematurely? By how long?:

* Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities?

* Please describe any other medical history or problems you feel should be brought to the doctor's attention:

* Please list your child's **allergies** to any medications or foods:

I HEREBY AUTHORIZE DR. MIN C. DO / DR. HELEN H. DO / HANNAH SONG TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL X-RAYS, IF NECESSARY, FOR MY ABOVE NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAINED TO ME PRIOR TO INITIATION OF SUCH PROCEDURES.

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

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition
_____	_____
_____	_____
Parent 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.