PATIENT INFORMATION:

NAME _____ (FIRST / MI / LAST) AGE _____ SEX _____

ADDRESS _____ APT. NO. _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ (MONTH / DAY / YEAR) SSN _____ - _____ - _____

E-MAIL _____

HOME PHONE ( ) _____

WORK PHONE ( ) _____

OTHER PHONE ( ) _____

_____ (DRIVERS LICENSE NUMBER) _____ (STATE)

EMPLOYER / OCCUPATION _____ ADDRESS _____

IN CASE OF EMERGENCY, CONTACT: _____ RELATIONSHIP _____ PHONE ( ) _____

ARE ANY OF YOUR FAMILY MEMBERS PATIENTS OF THIS PRACTICE? ☐ YES ☐ NO NAME _____ RELATIONSHIP _____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME _____ (FIRST / MI / LAST) RELATIONSHIP _____

ADDRESS _____ APT. NO. _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ (MONTH / DAY / YEAR) SSN _____ - _____ - _____

HOME PHONE ( ) _____

WORK PHONE ( ) _____

EMPLOYER _____

ADDRESS _____

PRIMARY DENTAL INSURANCE (Leave blank only if no dental benefits)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

SECONDARY DENTAL INSURANCE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

DENTAL HISTORY

WHAT IS THE REASON FOR THIS APPOINTMENT? _____

ARE THERE ANY SPECIFIC DENTAL PROBLEMS WE SHOULD BE AWARE OF? _____

DO YOU THINK YOU HAVE ANY DECAY OR CAVITIES? ☐ YES ☐ NO HOW OFTEN DO YOU BRUSH? _____

DO YOUR GUMS BLEED EASILY WHEN BRUSHING OR FLOSSING? ☐ YES ☐ NO HOW OFTEN DO YOU FLOSS? _____

DO YOU SUFFER FROM CHRONIC BAD BREATH OR BAD TASTE? ☐ YES ☐ NO

DO YOU HAVE ANY JAW JOINT CRACKING OR PAIN? ☐ YES ☐ NO

WHAT WAS THE PURPOSE OF YOUR LAST DENTAL APPOINTMENT? _____ WHEN WAS THAT? _____

WHEN WAS THE LAST TIME YOU HAD A DENTAL CLEANING? _____ NAME OF PREVIOUS DENTIST? _____

WHEN WERE THE LAST FULL MOUTH X-RAYS TAKEN OF YOUR TEETH? _____

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PATIENT TREATMENT CONSENT

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½% per month.

Patient / Parent or Guardian Signature: _____ **Date:** _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES	NO
ANY HEART PROBLEMS	☐	☐
HEART MURMUR*	☐	☐
MITRAL VALVE PROLAPSE*	☐	☐
HEART VALVE DEFECT*	☐	☐
HEART VALVE REPLACEMENT*	☐	☐
RHEUMATIC FEVER*	☐	☐
ARTIFICAL JOINT (HIP / KNEE)*	☐	☐
ANGINA	☐	☐
STROKE	☐	☐
HEART ATTACK	☐	☐
BYPASS	☐	☐
PACEMAKER	☐	☐
HIGH BLOOD PRESSURE	☐	☐
LOW BLOOD PRESSURE	☐	☐
ANY BLEEDING DISORDERS	☐	☐
ANEMIA	☐	☐
HEMOPHILIA	☐	☐
SICKLE CELL TRAIT	☐	☐
BLOOD TRANSFUSIONS	☐	☐

	YES	NO
DO YOU SMOKE	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
ASTHMA	☐	☐
BRONCHITIS	☐	☐
EMPHYSEMA	☐	☐
TUBERCULOSIS	☐	☐
SINUS TROUBLE	☐	☐
DIFFICULTY IN HEALING	☐	☐
DIABETES	☐	☐
THYROID PROBLEMS	☐	☐
ADRENAL/PITUITARY PROBLEMS	☐	☐
LIVER PROBLEMS / DYSFUNCTION	☐	☐
HEPATITIS / JAUNDICE	☐	☐
KIDNEY PROBLEMS / DYSFUNCTION	☐	☐
STOMACH TROUBLE / ULCERS	☐	☐
NERVOUS OR MENTAL DISORDER	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ALCOHOLISM	☐	☐
DRUG ABUSE	☐	☐
DAILY ASPRIN	☐	☐

	YES	NO
ALLERGIC REACTION (HIVES / SWELLING) TO:		
PENICILLIN	☐	☐
ERYTHROMYCIN	☐	☐
SULFA	☐	☐
CODEINE	☐	☐
ASPIRIN	☐	☐
LATEX	☐	☐
LOCAL ANESTHETIC (NOVOCAIN)	☐	☐
OTHER MEDICATIONS OR SUBSTANCES? Please list:	☐	☐
_____		
_____		
CANCER / TUMOR	☐	☐
OTHER GROWTHS	☐	☐
CHEMOTHERAPY / RADIATION THERAPY	☐	☐
SEXUALLY TRANSMITTED DISEASES	☐	☐
OTHER INFECTIOUS DISEASES	☐	☐
HIV / AIDS	☐	☐
ARE YOU PREGNANT?	☐	☐

*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? ☐ YES ☐ NO ☐ DON'T KNOW NAME OF ANTIBIOTIC: _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE? ☐ YES ☐ NO WHAT? _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO WHY? _____

PHYSICIAN'S NAME, ADDRESS AND PHONE: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, PILLS, OR TONICS? ☐ YES ☐ NO LIST: _____ FOR: _____
(I.E., BLOOD PRESSURE, BIRTH CONTROL, STEROIDS, HORMONES) _____ FOR: _____
_____ FOR: _____

IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED? ☐ YES ☐ NO EXPLAIN: _____

DATE	PATIENT / GUARDIAN SIGNATURE	DOCTOR / HYGIENIST SIGNATURE

Yearly Review of Patient Medical History

NO CHANGE	CHANGE	LIST:			
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				

MEDICAL ALERT RECOMMENDED:	YES	NO	DATE:	INTERVIEWER NOTES
1) _____				
2) _____				
3) _____				
PREMEDICATION RECOMMENDED:	YES	NO		
RX: _____				

FAMILY & AESTHETIC DENTISTRY
Dr. Keechun Hong
1003 Fourth Street
Laurel, Maryland 20707
301-725-1002

FINANCIAL POLICY

Thank you for selecting us as your dental health care provider. My staff and I are committed to your treatment being a positive experience. Please understand your financial obligations are considered part of your treatment.

The following is a statement of our financial policy. Please read and sign before being seen by Dr. Hong.

1. All patients are required to complete our Patient History and all Insurance forms before seeing the doctor. Full payment options include:

* Cash or Checks
* Visa/MasterCard/American Express/Discover
* Extended payment plan (with prior credit care approval through:
  Capital One, 3 months, 6 months, to 12 months, with no interest financing).

2. Patients with dental insurance are required to pay their Deductible and Estimated Portion of our fees at the time treatment is rendered. As a courtesy to you, we will accept assignment of insurance benefits. However, we do require 30-50% of the bill to be paid at time of service, based on the insurance co-payment. A refund check will be mailed to you if an insurance carrier pays more than we estimated.

3. A few of our patients have the misconception, that we know all the details about their insurance. Since the early 80's dental insurance guidelines have become more and more complicated to understand and control. Please understand filing insurance is a courtesy we extend to our patients, we must emphasize that as dental providers; our relationship is with our patients, not the insurance company. The insurance information we receive is limited to what is covered - not what is not covered. Your insurance is a contract between your employer and the insurance company. We sincerely encourage you to contact your insurance company to obtain a list of procedures and limitations not covered. Especially since any dental procedure that is not covered or has not been paid in full by your insurance carrier within 60 days, is your responsibility. This is important for you to know. A monthly billing fee of $5.00 is charged if not paid within the next 30 day billing cycle.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The adult accompanying a minor is responsible for full payment or co-payment of insurance on the day treatment is rendered.

Broken or Failed Appointments
Your scheduled appointment time has been reserved at your request. UNLESS CANCELLATIONS ARE RECEIVED AT LEAST 24 HOURS IN ADVANCE, A $20 FEE PER EACH THIRTY MINUTES OF MISSED APPOINTMENT TIME WILL BE CHARGED TO YOUR ACCOUNT. It is not our intention to charge you; however, we do require this notification to offer this time to another patient. Please help us avoid charging a fee by keeping your scheduled appointment.

I have read the above policies and agree to abide by them.

Print Name:_____ **Signed:**_____ **Date:**_____
(Patient, Parent, or Guardian)

HIPAA PRIVACY

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I,_____ (the patient or patient's legal representative), have been presented with Notice of Privacy Policy of Dr. Keechun Hong and Associates, and have been offered a copy of such policy to keep for my records.

_____(Please initial here) I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____(Please initial here) I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide services to me.

_____

Signature of Patient or Guardian Date

For Office Use Only

I,_____(Please print full legal name here), acting as _____(Please print relationship of official position with Provider) for Provider attempted to obtain the written acknowledgment of receipt of the Policy of provider on _____(Please insert date attempt was made), but acknowledgment could not be obtained because:

_____(Initial here) Patient or Patient's legal representative refused to sign.

_____(Initial here) Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgment.

_____(Initial here) Emergency circumstances prevented securing acknowledgment.

_____(Initial here) Other (Please specify)_____
_____
_____

_____

Signature of Provider Representative Date