New Patient Forms

Patient Information			
Patient Name:		Date of Birth:	
Street Address:	City:	State:	Zip:
Email:		Phone #:	

Responsible Party (if someone other than patient)			
Full Name:		Date of Birth:	
Relationship to Patient:			
Street Address:	City:	State:	Zip:
Email:		Phone #:	

Primary Insurance		
Subscriber Name:	Date of Birth:	Relationship to Patient:
Insurance Carrier:	Group #:	Subscriber ID #:

Secondary Insurance		
Subscriber Name:	Date of Birth:	Relationship to Patient:
Insurance Carrier:	Group #:	Subscriber ID #:

Additional Information	
How did you hear about our office?	
Previous Dentist:	Phone #:
When was your last dental cleaning?	When did you last have dental x-rays taken?
Preferred Pharmacy:	Phone #:

Acknowledgement of Privacy Practices and Office Policies

HIPAA Policy:

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 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 I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that this office uses e-mail, text, phone, and collection services for business purposes.

Initial

Health Care Release:

I authorize Lisa Hongying Pan DDS, PhD to release my medical and/or billing information to the following:

□ Spouse only □ Immediate Family □ Other _____ □ None

I authorize detailed messages to be left on the voicemail of the phone number and sent to the email on file.

□Yes □No

Patient Information Update Policy:

I agree to notify the office in the event of a change of address, telephone number, employment or insurance coverage.

Initial

Financial Policy:

All payment is due at the time of service and as the patient you are responsible for all charges. However, if you are a patient with documentation of private insurance, as a courtesy we will bill your insurance policy for you at no charge. Additionally, we will do our best to estimate your out-of-pocket portion for any given procedure, provide your plan's eligibility and benefit information, but we cannot guarantee accuracy. Should your insurance change without notification to our office, there are potential limitations through your policy regarding claim submission timelines. You are responsible for any issues that arise from delayed submission of treatment. Please plan to pay your deductible and any applicable estimated co-pay at the time of service.

Initial

Chair Reservation Policy:

As a small office, all missed appointments or late arrivals harm our ability to serve each of our patients effectively. All patients must call to cancel or change appointments in advance so that we may offer longer breaks to our employees or offer the time to a patient who may need it. We understand that this is sometimes not possible. However, patients who fail to call or reschedule without 2 full business days' notice or patients who do not show up for the scheduled appointment will be charged a $150.00/hr fee for EACH occurrence. If you fail to arrive within 10 minutes of your scheduled appointment time, we may consider that a "missed appointment" to ensure we give both you and those after you adequate time for scheduled treatment.

Initial

Bounced Check Policy:

We gladly accept payment in the form of a personal check. However, any payments returned for insufficient funds will be subject to a $25 fee payable by a cashier's check or credit card.

I have read, understand and agree to the HIPAA, Financial, Chair Reservation and Bounced Check policies. To the best of my knowledge, the questions on this form have been accurately and completely answered.

Patient Signature: _____ Date: _____

Print Name: _____

Medical and Dental History

Medical Information	YES	NO
Does your physician recommend that you receive antibiotic premedication for dental care?		
Are you now under the care of a physician for an ongoing condition?		
Physician Name: Phone:		
Have you had any serious illness, operation, or been hospitalized in the past five years? *If yes*, please explain below:		
Have you ever had an orthopedic total joint replacement (Hip, knee)?		
Have you ever had any radiation therapy or chemotherapy? *If yes*, please explain below:		
Have you taken, or are you scheduled to begin taking oral and/or intravenous bisphosphonates?		
Do you use or have you ever used tobacco?		
Do you use any substances for recreational purposes? *If yes*, please lists below:		

Medical Conditions		
Please indicate any of the following diseases, problems or symptoms that apply to you.		
Cardiovascular Condition (heart attack, heart murmur, high blood pressure, Endocarditis etc.)		
Respiratory Condition (Asthma, Emphysema, COPD, Tuberculosis, etc		
Diabetes		
Kidney/Urogenital Disorder (Renal failure, dialysis, etc		
History of Cancer- If yes; What type of cancer?		
Neurological Condition (stroke, seizures, MS, mental health disorders, etc)		
Blood/ Hematologic disorders (Anemia, Leukemia, bleeding disorders, etc)		
Gastrointestinal (GI) Disorder (Hepatitis, Acid Reflux, Crohn's, etc		
Musculoskeletal/Connective tissue disorder (Arthritis, Osteoporosis, Fibromyalgia, etc		
Growth/Development problem (developmental delay, learning disability, behavioral problems, etc		
Infectious disease (HIV/AIDS, MRSA, cold sores, STDs, etc)		
Eating disorder (Anorexia, Bulimia, etc)		
Immunosuppression (compromised immune system)		
Do you have any other problem, disease or condition not listed? *If yes*, please explain below		

Women Only		
Are you Pregnant? *If yes*, how many weeks? Due Date:		
Are you trying to become pregnant?		
Are you nursing?		
Are you taking birth control pills, fertility drugs or hormonal replacement?		

Medical and Dental History

Allergies	
Please list all substances/medications you are allergic to:	Reaction:
or N/A	

Medications	
Drug Name:	Dosage/Reason for taking
or N/A	

Dental Information	YES	NO
How often do you brush your teeth? / How often do you floss your teeth?		
Do you currently have any concerns about your teeth? If yes, please explain below:		
Are your teeth sensitive to cold, hot, sweet, or pressure?		
Do you have swelling in or around your mouth, face, or neck?		
Do you have bad breath, metallic taste, or unpleasant taste?		
Do you have any clicking, popping, or discomfort in your jaw?		
Do you clench or grind your teeth?		
Do you wear a night guard?		
Do you have sores, ulcers, or tumors in your mouth?		
Have you had any periodontal treatments? (Deep cleanings, gum grafting, etc.)		
Have you ever had orthodontic treatment? (Braces, retainers)		
Have you ever had local anesthetic (numbing) for dental purposes? ***If yes***, have you ever experienced any issues with local anesthetic please explain below:		
Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear):		

To the best of my knowledge, the questions on this form have been accurately and completely answered. I understand that providing any incorrect or incomplete information can be dangerous to my (or this patient's) health. It is my responsibility to inform Wellborn & Pan Dentistry's clinical staff of any changes in my medical status.

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I understand that this office uses my name and e-mail, text and collection services for business purposes.

Patient Signature: _____ Date: _____

Print Name: _____