KWON DENTAL

NEW PATIENT INFORMATION

❖ MARITAL STATUS (please circle): Single Married Divorced Widowed Other					
LAST		FIRST		MI	SEX M F
ADDRESS	UNIT	CITY		STATE	ZIP
PRIMARY EMAIL ADDRESS		DATE OF BIRTH	S.S.N.		
HOME PHONE	CELL		WORK		

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE NUMBER

DO YOU HAVE DENTAL INSURANCE? YES NO

NAME OF POLICY HOLDER	NAME OF EMPLOYER
POLICY HOLDER'S DATE OF BIRTH	NAME OF DENTAL INSURANCE
DENTAL INSURANCE ID# OR S.S.N.	DENTAL CUSTOMER SERVICE PHONE#

- ***LAST DENTAL CHECK-UP / CLEANING:** 6 Months Ago 7-12 Months Ago 13+ Months Ago
- *(FOR FEMALE): **ARE YOU CURRENTLY PREGNANT OR NURSING**? YES NO
- ***SMOKE OR USE ANY TOBACCO PRODUCTS, RECREATIONAL DRUGS**? YES NO
- ***DO YOU FLOSS YOUR TEETH DAILY?** YES NO SOMETIMES
- **DO YOUR GUMS BLEED WHEN FLOSSING?** YES NO
- ***HAVE YOU EVER BEEN TOLD THAT YOU HAVE PERIODONTAL DISEASE?** YES NO
- ***DO YOU CURRENTLY HAVING ANY DENTAL PAIN OR DISCOMFORT?** YES NO
- ***ARE YOUR TEETH SENSITIVE TO HOT/ COLD/ PRESSURE OR SWEETS?** YES NO
- ***DO YOU HAVE ANY MOBILITY IN YOUR TEETH?** YES NO
- ***ARE YOU AWARE OF ANY OF THE FOLLOWING:**
  CLENCHING GRINDING SNORING DIFFICULTY BREATHING BAD BREATH NONE
- ***HOW DO YOU FEEL ABOUT HAVING DENTAL TREATMENT DONE?** FINE NERVOUS PHOBIA
- ***IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU LIKE TO CHANGE?**
  COLOR/SHADE SHAPE FUNCTION OTHER ________________________________

PATIENT/ LEGAL GUARDIAN SIGNATURE (X) **DATE**

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN? YES NO

PHYSICIAN	PHONE NUMBER

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL APPOINTMENT? YES NO

IF YES, WHAT FOR?

PRESCRIBING DOCTOR	DOCTOR'S PHONE

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? YES NO

- ☐ ASPIRIN
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ PENICILLIN
- ☐ EPINEPHRINE
- ☐ LATEX
- ☐ ERYTHROMACIN
- ☐ SULFA
- ☐ OTHER:

PLEASE CHECK ALL THAT APPLY (WITHIN 5 YEARS)

- ☐ AIDS/HIV +
- ☐ ALLERGIES/HIVES/HAY FEVER
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTHRITIS / RHEUMATISM
- ☐ ARTIFICIAL JOINT (KNEE/HIP)
- ☐ ARTIFICIAL HEART VALVE
- ☐ ASTHMA / EMPHYSEMA
- ☐ BLOOD TRANSFUSION
- ☐ CANCER / TUMOR
- ☐ OTHER / NOTES:
- ☐ CHEMOTHERAPY
- ☐ CONGENITAL HEART LESIONS
- ☐ DIABETES
- ☐ EPILEPSY / SEIZURES
- ☐ FAINTING / DIZZY SPELLS
- ☐ FREQUENT HEADACHES
- ☐ GLAUCOMA
- ☐ KIDNEY PROBLEM
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEART PACEMAKERS
- ☐ HEART SURGERY
- ☐ HEMOPHILIA
- ☐ HEPATITIS A,B or C
- ☐ HIGH BLOOD PRESURE
- ☐ DRUG/ALCOHOL ADDICT
- ☐ LIVER DISEASE
- ☐ LOWER BLOOD PRESURE
- ☐ PSYCHIATRIC CARE
- ☐ RADIATION TREATMENT
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS of BREATH
- ☐ SINUS TROUBLE
- ☐ STROKE
- ☐ TAKING HORMONE MED
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ SLEEP APNEA

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO

NAME OF MEDICATION	DOSAGE OF MEDICATION	WHAT ARE YOU TAKING THIS FOR?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is MY responsibility to inform the KWON DENTAL of any changes in my medical status

PATIENT/ LEGAL GUARDIAN SIGNATURE (X) **DATE**

PROVIDER SIGNATURE (X) **DATE**

OFFICE POLICIES/PROTOCOLS

NEW PATIENT FORMS **_________(INITIAL)**

It is our obligation as a dental provider to care for our patients in the most careful and precise way possible. It is **imperative that all patient forms are thoroughly completed and kept up to date**. We will update your information yearly unless there are changes in between time, and **patient is responsible to keep their file updated**.

FINANCIAL POLICY	COLLECTION PROCESS
It is our financial policy to collect fees at the time that service is provided. Any unpaid balance is subject to review by a professional collection agency up to and including legal actions. **_________(INITIAL)**	Our office will attempt to contact you via phone, mail and/or email to resolve unpaid balances prior to your account being referred. If we are not able to obtain successful communication, your account will be referred to a third party for further assistance. **________ (INITIAL)**

INSURANCE HOLDERS **________ (INITIAL)**

It is the patient responsibility to keep insurance information up-to-date with the office at all times. Your benefits will be checked prior to your visit with our office. Any changes or updates to insurance information should be provided to us PRIOR to your dental appointment so we will have time to verify benefits and coverage. As a courtesy to our patients, we are happy to file claims with your insurance company for services performed. Please be sure to provide all dental and/or medical insurance information to our office PRIOR to your appointment. All co-pays and coinsurances are due at the time of service and any balance that is unpaid by the insurance will be billed to the patient accordingly. We will always attempt to get precise benefits from your insurance provider however there is **never a guarantee** of payment until they process the claim.

APPOINTMENT CONFIRMATIONS / RESCHEDULES/ CANCELLATIONS/ NO-SHOWS **________ (INITIAL)**

We value your time and would like to reserve appointment times that work well for your busy schedule. We reserve time exclusively for you. We normally **ALLOW A 10 MINUTE WINDOW** after your scheduled appointment time for your arrival before we attempt to contact you. If you do feel that you will be late or will not be able to show for your scheduled appointment, please call our office as soon as possible. If an unforeseen complication arises with your scheduled appointment, please call the office **at least 2 business days prior** to your reserved time.

CANCELLATIONS & NO-SHOW APPOINTMENTS	
With the Hygienist	**With the Dentist**
LESS THAN 48 HOURS OF CANCELLATIONS NOTICE, NO SHOWS WILL BE CHARGED AT **$50 PER HOUR**	LESS THAN 48 HOURS OF CANCELLATIONS NOTICE, NO SHOWS WILL BE CHARGED AT **$100 PER HOUR**
YOU ARE COMPLETELY RESPONSIBLE FOR THESE CHARGES IN FULL AMOUNT.	

I, _____________________________________DO ACKNOWLEDGE THAT I HAVE REVIEWED OVER THE OFFICE POLICIES AND PROCEDURES LISTED ABOVE AND AGREE TO ADHERE TO THE OFFICE PROTOCOLS.

PATIENT/ LEGAL GUARDIAN SIGNATURE (X) **DATE**

DALLAS DENTAL IMPLANT CENTER
HODONG KWON DDS PA 11722 Marsh Lane, Suite 364, Dallas, TX 75229 214-350-8608

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment plan directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for 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 or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____ D.O.B.___________

If under age, Name of Legal Guardian/Caretaker: ____

Relationship to Patient: ____

Patient or Legal Guardian Signature: ___________________________________Date:____________

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Patient Record of Disclosure

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information. The individual is also granted the right to request confidential communications or an alternate means of communication.

I wish to be contacted in the following manner: (check ALL that apply)

- ☐ By **TEXT** message on my cell phone (may include **detailed** information):
    - My number is: ________________________________
- ☐ It is **NOT OK** to text me detailed information.
- ☐ By my home telephone or cell phone (may include **detailed** information in **voice message**):
    - My number is: ________________________________
- ☐ It is **NOT OK** to leave me a voice message with detailed information.
- ☐ It is OK to contact me at work (may include **detailed** information):
    - My work number is: _______________________________
- ☐ It is **NOT OK** to leave me a message at work with detailed information.
- ☐ It is OK to leave a call-back number only at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

- ■ My spouse, whose name is : _______________________________ Phone: _____________________
- ■ My parent, whose name is : _______________________________ Phone: _____________________
- ■ Fill in other name you desire: ______________________________ Phone: _____________________

    Relationship to Patient: ______________________________

Patient Name: ____

If under age, Guardian/Caretaker: ____

Signature: ____Date:___________