

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
 E-mail: _____ I would like to receive correspondences via e-mail.

Section 2	Section 3
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired	Referred By _____
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Previous Dentist _____
Medicaid ID: _____ Pref. Dentist: _____	Emergency Contact _____
Employer ID: _____ Pref. Pharmacy: _____	Emergency Contact # _____
Carrier ID: _____ Pref. Hyg: _____	

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

Office Accounts & Insurance Authorization

- Patients are fully responsible for all balances and are expected to pay at the time of service, unless other arrangements have been made. Payment may be made by cash, debit, or credit card.
- Dental Insurance is a contract arrangement between patients and their insurance company. Our office will file claims as courtesy to our patients. There is no guarantee of payment from the insurance company. It is the patient's responsibility to pay any unpaid balances by the insurance company within 60 days after the time of service.
- Medicaid recipients only: Medicaid requires us by law to collect \$3.00 co-pay. Failure to do so results in our business being charged for fraudulence of a Federal Funded Government Program. If you cannot make it to an appointment we require a 48 hour notice prior. Cancellations affect other patients, if you cannot make it someone else may need that time. Missed appointments may result in the office discharging the patient and we will no longer be able to provide services.
- The office processes claims through a collection agency.
- The patient will be charged a \$25.00 fee if the appointment is not cancelled 48 hours prior to scheduled appointment time. If you cannot contact the staff, you may leave a message on our answering machine. This fee is the patient's responsibility and will not be filed with your insurance.

I hereby authorize Meit Hwar See, DDS to file dental claims for me along with all information regarding my dental condition and treatment. I further authorize my insurance company or other parties to direct payment to the office of Meit Hwar See, DDS under the terms of my agreement. In making this assignment, I also agree that any balance not paid by my insurance will be paid by me within 60 days from the time of services. In case of default, patient is liable for any and all collection and/or reasonable attorney fees.

Signature of Patient/Guardian: _____

Date: _____

PATIENT CONSENT FORM
(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, Meit Hwar See, DDS originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand Meit Hwar See, DDS reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Meit Hwar See, DDS is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Meit Hwar See, DDS has already taken action in reliance thereon.

With this consent, Meit Hwar See, DDS may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist Meit Hwar See, DDS in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Meit Hwar See, DDS may mail to my home or other designated location any items that assist Meit Hwar See, DDS in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Meit Hwar See, DDS may e-mail to me appointment reminders and patient statements. I have the right to request that Meit Hwar See, DDS restrict how it uses or discloses my PHI to carry out TPO. However, Meit Hwar See, DDS is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Meit Hwar See, DDS to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that Meit Hwar See, DDS has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Meit Hwar See, DDS may decline to provide treatment to me.

Print Patient Name: _____

Account Number: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Guilford Family Dentistry

Dr. Meit Hwar See, DDS, PLLC

4929 W. Market St. Suite 2106, Greensboro, NC 27407

Phone: 336-235-2808 Fax: 336-235-2715

guilfordfamilydentistry@hotmail.com

Authorization for Record Release/Receive (Both Medical and Dental)

I, (print Patient or Guardian name) _____ hereby authorize the doctors and staffs of the Guilford Family Dentistry to **receive** records or knowledge of concerning my dental health **from**

(Full Doctor Name) _____

Address _____

practice phone number _____

I also authorize the doctors and staffs of the Guilford Family Dentistry to **release** records or knowledge of concerning my dental health **to**

Full Doctor Name _____

Address _____

practice phone number _____

I also authorize the doctors and staffs of the Guilford Family Dentistry to **receive** records or knowledge of concerning my medical health **from**

Full Doctor Name _____

address _____

practice phone number _____

I also authorize the doctors and staffs of the Guilford Family Dentistry to **release** records or knowledge of concerning my medical health **to**

Full Doctor Name _____

address _____

practice phone number _____

Signed Patient or Guardian name _____

Print Patient or Guardian name _____

Date _____