Welcome

Fay Hu DMD
GENERAL DENTISTRY

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date _____

Name of Patient _____ DOB _____

SSN _____ Preferred Name /Title _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Emergency Contact Name _____

Phone _____ Relationship to Patient _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name _____ Age _____

Children Name(s) _____ Age _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____

(Home/Cell/Work) Phone _____ (Home/Cell/Work) Phone _____

Email _____

DOB _____ SSN _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

SSN _____ DOB _____ (Home/Cell) Phone _____

Name of Employer _____ Work Phone _____

Insurance Co. _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____

Additional Information

Whom may we thank for referring you? _____

How did you hear about us? _____

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Patient Medical History

Name of Patient _____ DOB _____ Yes No

Are you under a physician's care now? ☐ ☐

Name of Physician _____ Phone Number _____ Date of Last Exam _____

Have you ever been hospitalized for or had a major or had a major operation? If yes, specify _____ ☐ ☐

Have you ever had a serious head or neck injury? If yes, specify _____ ☐ ☐

Are you taking any medications, pills, or drugs? If yes, specify _____ ☐ ☐

Have you taken Fosamax, Boniva, Actonel, or medications containing bisphosphonates? If yes, specify _____ ☐ ☐

Are you on a special diet? If yes, specify _____ ☐ ☐

Do you use tobacco? If yes, specify _____ ☐ ☐

Do you use controlled substances? If yes, specify _____ ☐ ☐

Do you have any allergies? If yes, specify _____ ☐ ☐

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

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Diseases
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease

☐ Other: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

X _____ Date _____

Signature of Patient (or parent/guardian if minor)

Doctor's Notes

Doctor Signature _____ Date _____

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Patient Dental History

Name of Patient _____ DOB _____

Previous Dentist's Name _____ Phone Number _____

Address _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

What is the reason for your visit today? _____

Are your teeth sensitive to:	Yes	No
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad tastes?	☐	☐
Do you frequently get blisters / oral lesions?	☐	☐

Have you ever had:	Yes	No
Orthodontic treatment?	☐	☐
Oral surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

Do you:	☐	☐
Clench or grind your teeth (awake / asleep)?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐

Have you experienced:	☐	☐
Clicking or popping of the jaw?	☐	☐
Pain? (joint, ear, side of face)	☐	☐
Difficulty in opening or closing the mouth?	☐	☐
Difficulty in chewing on either side of the mouth?	☐	☐
Headaches, neckaches, or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐
Headaches, neckaches, or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐

Are you satisfied with your teeth's appearance?	☐	☐
Would you like to keep all of your teeth for life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐

If so, what is your biggest concern? _____
_____

Have you ever had an upsetting dental experience?	☐	☐

If yes, please describe _____
_____

Do your gums bleed or hurt?	☐	☐
Do you have loose teeth / changes in your bite?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Does food tend to get caught in between your teeth?	☐	☐

If yes, where _____
_____

Is there anything else about having dental treatment that you would like us to know? Any other concerns?

_____

_____

Are there any other family members that you feel are due for dental care?

_____

Fay Hu DMD's Financial Policy

Thank you for choosing Fay Hu DMD for your dental services and care. Our office is committed to providing you with the highest level of patient care. The payment for services rendered is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to starting any treatment. Please read carefully and contact us with any questions that may arise.

Appointment Charges: All appointments including Consultations, Exams, and Treatment carry a fee that is charged to the patient. If your insurance company does not pay for the appointment or charges, then it is your responsibility to pay any unpaid or denied balances. We will take our own necessary x-rays on every patient to diagnose what treatment is needed. You can request a quote of charges for your appointment at any time.

Payments Accepted: We accept the following forms of payment: cash, personal check (**with Driver's License and Check Verification**), Visa, Mastercard, American Express, and Discover. We also offer an extended payment plan option through Care Credit and The Lending Club.

All patient portion of fees, insurance co-pays, and deductibles are due at the time that services are rendered. The parent/legal guardian of any minor is responsible for their account. Any checks returned for insufficient funds are subject to an additional $30.00 fee.

Regarding Insurance: Personal information will be used in order to obtain insurance verification of benefits. Also, personal information will be sent on a claim to the insurance company to obtain payments for any visits. As a courtesy, we will file your claims to your insurance company. Your fees will be estimated on the basis of your primary insurance policy. It is ultimately your responsibility to keep track of any balances or maximums remaining or used from all doctors you have seen. If your insurance maximum is depleted at the time of the receipt of our claim, then you are responsible for your full account balance. **YOU MUST PRESENT YOUR PICTURE ID IN ORDER FOR US TO FILE YOUR INSURANCE.**

Please bring to each visit your current insurance card and/or information. We will do our best to estimate accurate insurance coverage and patient portions due. However, it must be understood that each PATIENT is ultimately responsible for the cost of services rendered. Your insurance company is required by law to pay on claims within 30 days. Whatever part of your claim that insurance does not pay after 30 days becomes your full responsibility. You are responsible for any fees incurred in obtaining any unpaid balances, which may include billing, collections, or attorney fees. Interest at the rate of 1% per month or 12% per year may be charged on balances unpaid after 90 days.

We appreciate the opportunity to serve your dental needs and welcome any questions you may have regarding our financial policy. By signing below, you acknowledge that you have read, understood, had any questions answered, and agree to abide by this policy.

SIGNATURE _____ **PRINT**_____**DATE**_____

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Patient Disclosure Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ Written Communication
- ☐ OK to mail to my home address
- ☐ Other _____

I allow you to discuss my clinical information, or answer questions in regards to my patient account, with the following person(s) (Check all that apply)

- ☐ Spouse _____
- ☐ Parent _____
- ☐ Child _____
- ☐ Other (specify) _____
- ☐ None

_____

Patient or Parent/Guardian Signature Today's Date

_____

Patient Name (Print) Patient Birth Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have viewed and had an opportunity to receive a copy of this office's Notice of Privacy Practices.

_____

Print Name Signature

_____

Date

Release

I, _____, grant Fay Hu DMD license to reproduce and use any photographs, still or video images, or audio recordings of me, and any testimonial I issue regarding my health care services at Fay Hu DMD, for any of the following purposes:

Fay Hu DMD's website, social media, online and printed articles, mass advertising mailings, brochures, booklets, flyers, reports, event displays, and other similar marketing materials and/or activities directed to prospective patients.
Fay Hu DMD is authorized to use all or any portion of the Marketing Materials without royalty or recompense of any kind, in unlimited quantities and for an unlimited period of time.

I release Fay Hu DMD and any of its associated or affiliate companies, their owners, directors, agents, employees, and appointed advertising agencies from all claims of any kind arising out of the use of the Marketing Materials as described in this release.

In the event I want Fay Hu DMD to cease using the marketing materials, I understand that I must provide 60 day written notice to Fay Hu DMD to discontinue the use of the marketing materials. Fay Hu DMD shall have the right to continue to use the marketing materials during the 60-day notice period and shall further have the right to exhaust its supply of products containing any portion of the marketing materials ordered or received prior to Fay Hu DMD's receipt of the written notice.

_____

Signature Print Name

_____

Date

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