Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? ____________________

ABOUT YOU

Name: ____________________ I prefer to be called ____________ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child Birth date: ____/____/____ Age: ________ SS #: ____________

Home Address: ____________________ City ____________ State ______ Zip ________

Home Phone: ( ) ____________ Work: ( ) ____________ ext ________

Cell: ( ) ____________ E-mail Address: ____________________

Employer: ____________________ how long there? _______ Occupation: ____________

Employer's Address: ____________________ City ____________ State ______ Zip________

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: ____________________ Birth date: ____/____/____ Relation: ________

Billing Address: ____________________ City ____________State ________ Zip________

Home Phone: ( ) ____________ Work: ( ) ____________ SS#: ____________

Employer: ____________________ How long there? _______ Occupation: ____________

SPOUSE INFORMATION

[ ] Same as above Name: ____________________ Birth date: ____/____/_____

Employer: ____________________ Work Phone: ( ) ____________ ext _______

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: ____________________ Phone: ( ) ________ Group/Policy#: ____________

Insured's Name: ____________________ Insured's Birth date: ____/____/____ Relation: ____________

Insured's Social Security #: ____________ Insured's Employer: ____________________

Secondary Insurance

Insurance Co. Name: ____________________ Phone: ( ) ________ Group/Policy #: ____________

Insured's Name: ____________________ Insured's Birth date: ____/____/____ Relation: ____________

Insured's Social Security #: ____________ Insured's Employer: ____________________

We send appointment reminders by e-mail and text. If you would like to opt out, please indicate here.

[ ] do not e-mail [ ] do not text message

MEDICAL HISTORY INFORMATION

Name of Physician: ________________________ Phone: ( ) ____________________

Do you have or have ever had any of the following? Please check those that apply:

☐Allergies/Hay Fever	☐Diabetes (Type I/II)	☐Heart Surgery*	☐Rheumatic Fever
☐Anemia	☐Epilepsy or Seizures	☐Hepatitis	☐Rheumatism
☐Angina	☐Neurological Problems	☐High Blood Pressure	☐Sickle Cell Disease
☐Arthritis	☐Fainting or Dizziness	☐HIV*/AIDS	☐Sinus Problems
☐Artificial Joints*	☐Jaundice	☐Kidney Problems	☐Surgical Shunt*
☐Artificial Heart Valves*	☐Frequent Cough	☐Liver Problems	☐Stroke
☐Asthma	☐Glaucoma	☐Mental Disorders	☐Thyroid Problems
☐Breathing Problems	☐Heart Disorder	☐Mitral Valve Prolapse*	☐Tuberculosis
☐Cancer	☐Heart Infection*	☐Osteoporosis	☐Ulcers
☐Chemical Dependency	☐Heart Murmur*	☐Radiation Treatment	☐Venereal Disease
☐Chemotherapy	☐Heart Pacemaker*	☐Respiratory Problems	☐Excessive bleeding from cut or extraction

*This condition may require antibiotic pre-medication for certain dental procedures

Need to premedicate? YES/NO if yes, what is the name of the antibiotic? ____________________

Do you have any health problems that were not listed above or that need further clarifications? YES/NO
If yes, explain: ____

Are you currently under the care of a physician? YES/NO
If yes, explain: ____

Have you been admitted to a hospital or needed emergency care during the past two years? YES/NO
If yes, explain: ____

Are you taking any medications or herbals? YES/NO
If yes, list: ____

Are you allergic to any medications or substances? YES/NO If yes, please check box below:
Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other: ____________________

Do you smoke or use tobacco? How much/How long? ____________________

Do you use Alcohol? How often/How much? ____________________

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

Signature ____Date ____________

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.
Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.
Please help us better understand your dental health needs and goals by answering the following questions:

Date of last dental visit: _______________ Name of previous Dentist: _______________________________________

☐Teeth Sensitive to cold, heat, sweets or pressure
☐Bleeding gums – how long? _________
☐Food impaction
☐Bad Breath/Unpleasant taste
☐ Excessive Thirst/Dry Mouth
☐Previous periodontal treatment
☐Unfavorable experience
☐Extraction Complication
☐Clenching/Grinding
☐Pain around ear
☐Wear Nightguard
☐Orthodontics/Braces
☐Frequent Blisters on lips/mouth
☐Use Electric Toothbrush
☐Texture of toothbrush ___________
☐Frequency of Brushing __________
☐Use dental floss
☐Interdental cleaners

1. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
2. My greatest fear about dental treatment is: [ ] **discomfort/pain** [ ] **expense** [ ] **time it takes**.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable.**
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor.**
6. I would say that my main concerns with my dental health are:

____

7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [ ] **Yes** [ ] **No**

Please check which statement below best represents the level of dental health you wish to achieve.
(Some people begin at one level and progress to a higher level over time.)

HEALTH LEVEL I - Emergency Care
[ ] I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

HEALTH LEVEL II - Maintenance Care
[ ] I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

HEALTH LEVEL III - Comprehensive Care
[ ] I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

HEALTH LEVEL IV - Comprehensive & Cosmetic Care
[ ] I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. If you are unable to keep a scheduled appointment, we ask that you give our office a minimum of 2 business day notice. Without this notice, a $45 cancellation fee will be assessed to your account. Changes in appointments are not accepted over voicemail, email or text.

FINANCIAL POLICY

Thank you for choosing Elke Cheung DMD PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Payment for service is due before or at the time treatment is rendered unless payment arrangements have been approved in advance. We accept cash, checks, Visa, MasterCard, Discover, American Express, or CareCredit.

Please note:

If you have dental insurance, we will gladly submit claims for you as long as you provide us with the proper information prior to the time of your visit. We expect payment of your deductible and any other estimated patient portion not covered by your insurance prior to or when treatment is rendered. We will provide an estimate of payment but please understand that it is impossible to estimate exactly what your insurance company will pay for your treatment. The estimate of coverage is not a guarantee of payment, as eligibility, policy provisions and possible charges from other offices affect insurance payment. We must emphasize, as your dental care provider, our relationship is with you, the patient, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract and cannot be responsible for lapse of coverage or policy restrictions. We cannot be responsible for non-payment by your insurance company for any reason, although we will do our best to help you resolve non-payment issues with your insurance company. While the submission of dental claims is a courtesy that we extend to our patients, the total fee is the patient's obligation. Should any problem arise with a claim, we encourage you to contact us promptly for assistance in the management of your account. In summary, your insurance company may not pay the full estimated portion. You are responsible for all treatment charges not paid by your insurance company.

There is a $35 fee for processing a returned check. We reserve the right to reject check payments once a returned check occurs. We do not accept postdated checks.

We charge a $15 late fee on balances over 60 days and $15 every following month that balance is not paid.

A 40% collection fee will be added to balances that are unpaid and are sent to our collection agency.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. Elke Cheung, DMD. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize Dr. Elke Cheung, DMD to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. Elke Cheung, DMD.

I understand and will comply with office **Appointment Policy.**
I understand and will comply with the office **Financial Policy**.
I understand and agree to the General **Consent to Treatment.**
I authorize the **Release of Information.**

Signature ____ Date __________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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