PATIENT NAME: _____

MEDICAL HISTORY

1) ARE YOU UNDER A PHYSICIANS CARE NOW ◯ YES ◯ NO

2) HAVE YOU EVER BEEN HOSPITALIZED OR HAD MAJOR SURGERY? ◯ YES ◯ NO

IF YES, PLEASE LIST: _____

3) HAVE YOU EVER HAD A SERIOUS HEAD/NECK INJURY? ◯ YES ◯ NO

4) ARE YOU TAKING ANY MEDICATIONS? ◯ YES ◯ NO

IF YES, PLEASE LIST: _____

5) DO YOU TAKE, OR EVER TAKEN, PHENFEN OR REDUX? ◯ YES ◯ NO

6) ARE YOU ON A SPECIAL DIET? ◯ YES ◯ NO

7) DO YOU USE TOBACCO? ◯ YES ◯ NO

8) DO YOU USE CONTROLLED SUBSTANCES? ◯ YES ◯ NO

9) WOMEN: ARE YOU PREGNANT? ◯ YES ◯ NO ARE YOU NURSING? ◯ YES ◯ NO

10) ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE

☐ ACRYLIC ☐ METAL ☐ LATEX ☐ LOCAL ANESTHETICS ☐ SULFA ☐ OTHER (_____)

11) DO YOU HAVE ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

☐ AIDS/HIV	☐ CHEST PAINS	☐ FREQUENT HEADACHES	☐ IRREGULAR HEARTBEAT	☐ SCARLET FEVER
☐ ALZEIMERS DISEASE	☐ COLD SORES	☐ GENITAL HERPES	☐ KIDNEY PROBLEMS	☐ SHINGLES
☐ ANAPHYLAXIS	☐ CONGENITAL HEART DISORDER	☐ GLAUCOMA	☐ LEUKEMIA	☐ SICKLE CELL DISEASE
☐ ANEMIA	☐ CONVULSIONS	☐ HEY FEVER	☐ LIVER DISEASE	☐ SINUS TROUBLE
☐ ANGINA	☐ CORTISONE MEDICATION	☐ HEART ATTACK	☐ LOW BLOOD PRESSURE	☐ SPINA BIFIDA
☐ ARTHRITIS / GOUT	☐ DIABETES	☐ HEART MURMUR	☐ LUNG DISEASE	☐ STOMACH DISEASE
☐ ARTIFICIAL HEART VALVE	☐ DRUG ADDICTION	☐ PACE MAKER	☐ MITRAL VALVE PROLAPSE	☐ STROKE
☐ ARTIFICIAL JOINT	☐ EASILY WINDED	☐ HEART DISEASE	☐ PAIN IN JAW	☐ SWELLING OF LIMBS
☐ ASTHEMA	☐ EMPHYSEMA	☐ HEMOPHILIA	☐ PARATHYROID DISEASE	☐ THYROID DISEASE
☐ BLOOD DISEASE	☐ EPILEPSY / SEIZURES	☐ HEPATITIS A	☐ PSYCHIATRIC CARE	☐ TONSILLITIS
☐ BLOOD TRASNFUSTION	☐ EXCESSIVE BLEEDING	☐ HEPATITIS B OR C	☐ RADIATION	☐ TUBERCULOSIS
☐ BREATHING PROBLEM	☐ EXCESSIVE THIRST	☐ HERPES	☐ RECENT WEIGHT LOSS	☐ TUMORS/GROWTHS
☐ BRUISE EASILY	☐ FAINTING / DIZZINESS	☐ HIGH BLOOD PRESSURE	☐ RENAL DIALYSIS	☐ ULCERS
☐ CANCER	☐ FREQUENT COUGH	☐ HIVES / RASH	☐ RHEUMATIC FEVER	☐ VENEREAL DESEASE
☐ CHEMOTHERAPY	☐ FREQUENT DIARRHEA	☐ HYPOGLYCEMIA	☐ RHEUMATISM	☐ YELLOW JAUNDICE

12) HAVE YOU HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ◯ YES ◯ NO

IF YES, PLEASE LIST: _____

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 (PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

Charles E. Lee III
dentistry

NEW PATIENT PROFILE

NAME _____

DATE _____

1) WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

2) HOW HAVE YOUR DENTAL EXPERIENCES BEEN IN THE PAST?

◯ EXCELLENT ◯ MEDIOCRE ◯ FRIGHTENING/PAINFUL

IF FRIGHTENING/PAINFUL, WHAT CAN WE DO TO HELP YOU WITH THIS? _____

3) HAVE YOU HAD REGULAR CHECK UPS AND CLEANINGS? ◯ YES ◯ NO

4) APPROXIMATELY WHEN WAS YOUR LAST CLEANING? _____

5) IF APPLICABLE, WHY HAVE YOU NEGLECTED YOUR DENTAL HEALTH?

☐ MONEY ☐ TIME ☐ PROCRASTINATION ☐ PAIN/FEAR

6) DO ANY OF YOUR FAMILY MEMEBERS WEAR DENTURES? ◯ YES ◯ NO

IF YES, WHO? _____

7) DO YOUR GUMS BLEED WHEN YOU BRUSH? ◯ YES ◯ NO FLOSS? ◯ YES ◯ NO

8) HOW OFTEN DO YOU BRUSH? _____

9) HOW OFTEN DO YOU FLOSS? _____

10) DO YOU LIKE YOUR SMILE? ◯ YES ◯ NO

11) WHAT WOULD YOU CHANGE ABOUT YOUR SMILE? _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand these rights and understand that the Notice of Privacy Practices containing a description of thee uses and disclosures of my information is available for my review.

Patient Name: _____

Relationship (if minor): _____

Signature: _____ Date: _____

I have attempted to obtain patient's signature in acknowledgement of this notice, but was unable to do so as documented below:

Name: _____ Date: _____

Reason: _____

Charles E. Lee III
dentistry

PATIENT REGISTRATION

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMERGENCY CONTACT: _____

BIRTHDATE: _____ AGE: _____ SS#: _____

SEX: ◯ M ◯ F MARITAL STATUS: _____ EMAIL: _____

RESPONSIBLE PARTY NAME (IF OTHER THAN PATIENT): _____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

BIRTHDATE: _____ SS#: _____

PRIMARY DENTAL INSURANCE: _____

NAME OF SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

INSURANCE CO ADDRESS: _____ CITY, STATE, ZIP: _____

INSURANCE CO PHONE NUMBER: _____

SECONDARY DENTAL INSURANCE: _____

NAME OF SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

INSURANCE CO ADDRESS: _____ CITY, STATE, ZIP: _____

INSURANCE CO PHONE NUMBER: _____

PERSONAL HEALTH INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Release of Information:

I authorize the release of any and all information including diagnosis, financial, dental records and examination rendered to me and claims information. This information may be released to:

Spouse _____

Child _____

Other _____

Information is not to be released to anyone.

*This *Release of Information* will remain in effect until terminated by me in writing.

Messages:

Please call my ◯ home ◯ cell ◯ work at _____

If unable to reach me,

◯ please leave a detailed message

◯ please leave a message asking me to return your call

_____

The best time to reach me is ◯ am ◯ pm

I understand that this office will try to accommodate my wishes about my contact information but may have to contact me at other numbers if unable to contact me at my requested number and/or location.

Signature _____ Date _____

FINANCIAL POLICIES

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allow you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always able to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

INSURANCE:
We will file your insurance if we are a preferred provider or we are utilizing your out-of-network benefits. We will file a claim for the date of service twice. If, after filing the claim twice, the insurance company has not paid the claim, it becomes patient responsibility.

OPTIONAL PAYMENT TERMS:
Full Pay Cash Discount: We offer at 10% accounting courtesy for all treatment that is paid in full at the time of service and insurance is NOT being filed.

Major Service-Two Payment Option: We offer a two payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of patient responsibility at the first appointment and the other half at the seat date appointment.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. We accept cash, checks (for checks over $500 funds will be verified), MasterCard, Visa, Discover and American Express. Financing is available through CareCredit-Ask us for details.

BROKEN APPOINTMENTS:
A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $40.00 cancellation fee (emergencies are an exception).

COLLECTIONS:
I understand that in the event that my account becomes 90 days past due and is turned over to our collection agency, I will be responsible for all collection expenses incurred.

Signature _____ Date _____