KENNETH M. K. WOO, D.D.S. L.L.C.

WELCOME TO DR. WOO'S PRACTICE! WE WOULD LIKE TO GET TO KNOW YOU BETTER!!!

PATIENT INFORMATION

PLEASE PRINT INFORMATION **CLEARLY IN INK**!!!

Name ____ Age ______ Sex ________
First Middle Initial Last

Address ____

City ____________________________ State _______ Zip Code ______________

Home Phone ______________________ Cell Phone ______________________

Work Phone ______________________ Ext. ____________ Marital Status ________

Social Security # (WHEN NECESSARY) ______________________ Date of Birth _____/_____/_____
Month Date Year

Occupation ______________________ Hobbies ______________________

Company/Employer Name____

E-Mail Address ____________________ Interest in e-mail communication/texting OYes O No

Spouse's Name ____________________ Spouse's Work Phone ______________________

EMERGENCY INFORMATION

In case of emergency whom may we contact?

Name ______________________ Relationship ______________________

Home Phone ____________________ Work Phone______________________

Primary physician's name ____________________ **Office phone** ____________________

Whom may we thank for referring you to our office? ______________________

DENTAL INSURANCE INFORMATION

Do you have dental insurance? Yes [ ] No [ ]

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
If yes, name of the dental insurance ___________	If yes, name of the dental insurance _____________
Name of the policy holder___________________	Name of the policy holder_____________________
Date of birth ______________________________	Date of birth ________________________________
SSN or ID # ______________________________	SSN or ID #__________________________________
Group number of policy ____________________	Group number of policy ______________________

Reduced Rate Program:

Name of the plan ____

Name of the policy holder ____

Date of birth of policy holder____

SSN or ID # of the policy holder ____

Group number for policy ____

- **To the best of my knowledge the above insurance information is correct.**

X ____ ___________________

Patient / Responsible Party Signature **Today's Date**

PREFERRED METHOD OF PAYMENT

PORTION NOT COVERED BY THE INSURANCE

[ ] Cash in full

[ ] Check in full with **two** valid IDs

[ ] Credit cards in full (VISA, MasterCard, Discover, and American Express)

FOR ALL MAJOR TREATMENTS, A NON-REFUNDABLE 50% DEPOSIT MUST BE MADE PRIOR TO THE APPOINTED TREATMENT DATE

PAYMENT ARRANGEMENTS **MUST** BE MADE BEFORE TREATMENT BEGINS.

PAYMENT PLANS ARE AVAILABLE THROUGH CARE CREDIT

MEDICAL HISTORY

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, please explain: ______________________________

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

If yes, please explain: ______________________________

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No If yes, please explain: ________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

○ Yes ○ No If yes, please explain: ______________________________

Are you on a special diet? ○ Yes ○ No Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Are you allergic to any of the following? □None □ Penicillin

□ Aspirin □ Codeine □ Local Anesthetics □ Acrylic □ Metal

□ Latex □ Sulfa drugs □ Other If yes, please explain: ______________________________

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

□ AIDS/HIV Positive	□ Cortisone Medicine	□ Hemophilia	□ Radiation Treatments
□ Alzheimer's Disease	□ Drug Addiction	□ Hepatitis A	□ Recent Weight Loss
□ Anaphylaxis	□ Easily Winded	□ Hepatitis B/C	□ Rheumatic Fever
□ Anemia	□ Emphysema	□ Herpes	□ Jaundice
□ Angina	□ Epilepsy/Seizures	□ High Blood Pressure	□ Scarlet Fever
□ Arthritis/Gout	□ Excessive Bleeding	□ High Cholesterol	□ Shingles
□ Artificial Heart Valve	□ Excessive Thirst	□ Hives/Rash	□ Sickle Cell Disease
□ Artificial Joint	□ Dizziness	□ Hypoglycemia	□ Sinus Trouble
□ Asthma	□ Frequent Cough	□ Irregular Heartbeat	□ Stomach Disease
□ Blood Disease	□ Diabetes	□ Kidney Problems	□ Stroke
□ Blood Transfusion	□ Frequent Headaches	□ Leukemia	□ Swelling of Limbs
□ Breathing Problem	□ Genital Herpes	□ Liver Disease	□ Thyroid Disease
□ Bruise Easily	□ Glaucoma	□ Low Blood Pressure	□ Tonsillitis
□ Cancer	□ Hay Fever	□ Lung Disease	□ Tuberculosis
□ Chemotherapy	□ Heart Attack	□ Mitral Valve Prolapse	□ Tumors/Growths
□ Cold Sores	□ Heart Murmur	□ Osteoporosis	□ Ulcers
□ Congenital Heart Disorder	□ Heart Pacemaker	□ Pain in Jaw Joints	□ Venereal Disease
□ Psychiatric Care	□ Heart Disease	□ Parathyroid Disease	□ NONE

WOMEN ONLY

Are you currently pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

ANNUAL MEDICAL HISTORY REVIEW AND UPDATES (For Existing Patients Only)

DATE	NO CHANGE	CHANGE	LIST CHANGE	PATIENT SIGNATURE	DR/STAFF SIGNATURE
________	□	□	____________	____________	________
________	□	□	____________	____________	________
________	□	□	____________	____________	________
________	□	□	____________	____________	________

SIGNATURE OF PATIENT, PARENT or GUARDIAN ______________________________ **DATE**__________

DENTAL INFORMATION

What is the reason for this appointment? ____

When was the last full mouth x-ray taken of your mouth? ______________________________________

How would you describe your dental health? Excellent [ ] Good [ ] Fair [ ] Poor [ ]

Is there anything that concerns you about the appearance of your teeth? __________________________

Are there any chips, stains on your teeth or gap in between your teeth that concern you?____________

Would you like whiter teeth? Yes [ ] No [ ]

Have you ever considered bleaching, bonding, braces? Yes [ ] No [ ]

Do your gums bleed while you brush or floss? Yes [ ] No [ ]

Have you noticed any gum swelling around teeth? Yes [ ] No [ ]

Have you ever had any gum treatment before? Yes [ ] No [ ]

Are your teeth sensitive to: Hot [ ] Cold [ ] Biting pressure [ ] Sweet [ ] none [ ]

Do you frequently have food trap in your teeth? Yes [ ] No [ ]

Do you chew on one side of your mouth? Yes [ ] No [ ]

If yes, which side? Left [ ] Right [ ]

Do you have any jaw joint cracking or pain? Yes [ ] No [ ]

Have you ever had any previous injuries to the face or jaw? Yes [ ] No [ ]

Do you have any artificial teeth (Bridge, Crown, Partial or Denture)? Yes [ ] No [ ]

If yes, would you like to replace any of them? Yes [ ] No [ ]

PAYMENT AND INSURANCE POLICIES

- I authorize the dentist(s) or designated staff treating me to perform such aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist(s) to perform all recommended treatment and therapeutic procedures to include administrating medications as prescribed by the dentist(s) and mutually agreed upon by me.
- **This office only performs composite/resin fillings (tooth colored). Patients are fully responsible for any difference which is not paid for by the insurance company.**
- I assign all dental insurance benefits to the extent permitted under my dental insurance policy to the practice. I agree and allow the provider to submit insurance forms and receive payment directly from the insurance carrier(s) with the notation "Signature on File." I authorize my dentist(s) to release treatment records / x-rays or any information deemed pertinent to my insurance carrier as necessary and/or requested.
- I understand that insurance benefits are **ESTIMATES ONLY** based upon the information available to the provider by my insurance carrier at the time of service. **ELIGIBILTY IS NOT A GUARANTEE OF PAYMENT**, and actual benefits are determined only when a claim is processed. The estimated patient portions are due at the time of the treatment. Therefore, Kenneth Woo DDS, LLC is not responsible for how my insurance company handles claims or what they pay on a claim. Once a claim is processed, any difference is due upon the receipt of a statement.
- **I agree that for all major treatments, a nonrefundable 50% deposit is required to be made prior to the date of the scheduled treatment date. Unless prior arrangement is made with Carecredit, the remaining balance is due prior to final delivery or on impression date.**
- I agree to pay for all the services rendered on my behalf or my dependents at the time of service. I agree that my unpaid claims that the carrier does not pay or any balance that extends beyond 30 days from the date of service will be assessed a service charge of 1.5% or a $20.00 late fee per month, whichever is greater. In the event that this balance should be submitted to collections, there will be a fee charge to the account of $50.00. A $20 charge will be applied to the account for each returned check and/or declined credit card transaction. If these fees should be added to your account, you will be notified my mail or by phone. Fees are subject to change. In the event of a fee change the responsible party or patient will be notified prior to any dental treatment.
- I HAVE READ THE ABOVE POLICIES, AGREE TO THEM AND HAVE HAD THE OPPORTUNITY TO HAVE ALL MY QUESTIONS ANSWERED.

X ____________________ X__________________________ _____________

Print patient full name **Patient / Responsible Party Signature** **Today's Date**

Your Informed Consent For Treatment

Thank you for placing your trust in us. In order for us to provide you with the best possible care and service, we need your permission. Please read the following carefully, and initial or sign where indicated. Please don't hesitate to ask us ANY questions you may have. It is truly our pleasure to help you!

AUTHORIZATION

I authorize Dr. Kenneth Woo and his professional staff to perform any appropriate diagnostic procedures and treatment as may be necessary for proper dental care and oral health;
gather a complete and accurate dental and medical history to aid in diagnosis and any necessary treatment planning; inform me of any dental conditions currently present, including their estimated levels of severity and projected paths of progression; and make any necessary treatment recommendations, including any known, available options, and their risks and benefits, to correct any diagnosed conditions;

PRIVACY

I authorize the release of any and only relevant information concerning my medical or dental health to any appropriate dental or medical practitioners, selected by me or Dr. Woo, on an "as needed" basis, to assist them in my care. Otherwise, **all information is to be kept strictly confidential**.

MULTIMEDIA RECORDS

I authorize the right and give permission to copyright and/or publish, or use my written or spoken statements, or photographic pictures of me, or those in which I may be included in whole or in part, or reproductions thereof made through any form of media, for art, advertising, trade, or any other lawful purpose, as individually agreed upon by me, including the use of my own name in whole or in part. I hereby waive any right to inspect and/or approve the finished product or the copy that may be used in conjunction with it, or the use to which it may be applied. I hereby release, discharge, and agree to save the practice, doctor, and staff from any liability for using any materials. Note: We will never use any of the above materials for promotional purposes without your express permission. Initial: ______

INSURANCE

I authorize the release of any relevant information concerning my medical or dental health to my insurance company for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits, which would otherwise be payable to me, directly to Dr. Woo's office, unless alternate arrangements are made, and only after my insurance information has been verified by Dr. Woo and his staff.

APPOINTMENT POLICY

For any necessary changes or cancellations of appointments, I_______ (Initial) will notify Dr. Woo & Associates 48 hours or the equivalent to 2 business days prior to my scheduled appointment time. If changes or cancellations are given less than 48 hours or the equivalent to 2 business days prior to my scheduled appointment, a charge of $50 will be applied towards my account. This balance will need to be satisfied prior to scheduling another appointment. If a patient accumulates a total of (3) failed appointments without the proper notice, we reserve the right not to schedule future appointments.

Signed ___________________________________ Date _____ - _____ - _____
Patient (or Parent/Guardian if Patient is under 18)

___________________________________ ______________________________
(Please Print Name) Patient's Name (if under 18)

HIPPA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_______day of __________,20___.

Print Patient Full Name: ____

Patient, Guardian signature (seal) :