PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____ Gender: Male/Female

Patient's name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies_____

Favorite Toy_____ Favorite Person_____

Parent or guardian name _____

Who may we thank for referring you to our office? _____

Would you like to receive appointment reminders via text message? YES NO

Would you like to become friends with Dr. Cheryl Y. Lee on Facebook.com to receive special offers? YES NO

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____

Social Security # _____ Birthdate _____Work Phone_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Home address_____
Street City Zip

Home Phone_____ Cell Phone_____

I am the parent/guardian, or personal representative of _____
Please Print Name of Minor Child

and there are no court orders now in effect that prohibit me from signing this consent. I hereby grant authority to the dentist(s) and/or all of her designated staff in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedure, anesthetics and/or drugs.
All services are rendered and accepted under the terms and conditions listed above:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

_____ _____
Signature of Parent, guardian or Personal Representative Date

_____ _____
Please print name of Parent, guardian or Personal Representative Date

Office Policies Including Insurance/Financial Agreement: Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

Anyone 18 years old and under MUST be accompanied by a parent or guardian. Our dental office provides **as a courtesy** Reminder calls regarding your next dental visit. **This call is a courtesy ONLY and in NO way an excuse for broken appointments**. To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee. Broken appointments will be rescheduled and subject to a $35 fee. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept. It is the responsibility of the patient to notify the dental office in advance of dental appointments if there are any changes in: insurance, employment, medical history, contact information (telephone number, address, or email). NSF Checks Recovery Fee is $35. Telephone calls are triaged by our Front Desk Staff or Assisting Staff. Please know that my staff is an extension of me and all patient matters have been discussed with me. However, when it is necessary to call you myself, please understand that all calls are returned at the end of the patient care day.

We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit. If you choose to pay cash in full, on or before the treatment day we will gladly extend a 5% cash savings.

Your dental insurance is a contract between you, your employer, and the insurance company. The dental office is an OUT OF NETWORK (Preferred Provider Organization) provider of services with all insurance companies. Diagnostic and Treatment codes will not be altered for insurance purposes. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. As a courtesy, we will file your claim on your behalf with proper identification (insurance card, social security number and current state issued ID). I understand that I am required to pay my “Estimated Patient Portion” and any deductible due, to Dr. Cheryl Y. Lee’s dental office at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient’s responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old.

I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that (60) days after services have been rendered there may be a late charge of 1.5% applied to my account for any overdue balance that is my responsibility. An account with an unpaid balance past (90) days wills be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt.

There are no payment plans unless discussed with the Office Manager in advance of services. We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

Dr. Lee reserves the right to refuse/terminate treatment of service to anyone for any reason at any time.

I have read and understand the above office polices.

_____	_____	_____
Print Name	Signature	Date

MEDICAL HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable.

Are you in good health?	Yes	No
Date of last physical examination		
Are you now under the care of a physician	Yes	No
If so, what is the condition being treated?		
Have you ever had a serious illness or operation?	Yes	No
If so, what illness or operation?		
Have you ever been hospitalized?	Yes	No
If so, what was the problem?		
Are you taking any medication?	Yes	No
If so, please provide list of all OTC, Prescription, and/or Herbal Supplements and Dosage.		
Are you using any recreational drugs (marijuana, cocaine, etc.)?	Yes	No
Have you ever been premedicated with antibiotics for your dental treatment?	Yes	No
Are you sensitive or allergic to any drugs or materials?	Yes	No
☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex		
If other what drugs?		

Female Patients Only

Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No

Do you have or have you had any of the following: (Please circle **Y** for Yes or **N** for No – answer all conditions)

Y	N	Anemia	Y	N	Heart Murmur	Y	N	Cortisone Medicine
Y	N	Herpes	Y	N	Liver Disease	Y	N	Allergies to Metals
Y	N	Stroke	Y	N	Blood Disease	Y	N	Excessive Bleeding
Y	N	Ulcers	Y	N	Drug Addiction	Y	N	High Blood Pressure
Y	N	Diabetes	Y	N	Kidney Disease	Y	N	HIV Related Complex
Y	N	Glaucoma	Y	N	Stomach Ulcers	Y	N	Respiratory Disease
Y	N	Arthritis	Y	N	Angina Pectoris	Y	N	Epilepsy or Seizures
Y	N	Hay Fever	Y	N	Mental Disorder	Y	N	Psychiatric Treatment
Y	N	Tonsillitis	Y	N	Cerebral Palsy	Y	N	Hepatitis or Jaundice
Y	N	Asthma	Y	N	Thyroid Disease	Y	N	Difficulty in Swallowing
Y	N	Hemophilia	Y	N	Tuberculosis (TB)	Y	N	Heart Ailments or Attack
Y	N	Cold Sores	Y	N	Rheumatic Fever	Y	N	Congenital Heart Lesions
Y	N	Emphysema	Y	N	Blood Transfusion	Y	N	X-ray or Cobalt Treatment
Y	N	Rheumatism	Y	N	Joint Replacement	Y	N	Fainting Spells or Seizures
Y	N	Chicken Pox	Y	N	Nervous Disorders	Y	N	Chemotherapy (Cancer, Leukemia)
Y	N	Bruise Easily	Y	N	Tumors or Growth	Y	N	Radiation Treatment of any kind
Y	N	Head Injuries	Y	N	Allergies or Hives	Y	N	Venereal Disease (Syphilis, Gonorrhea)
Y	N	Heart Failure	Y	N	Pain in Jaw Joints	Y	N	Acquired Immune Deficiency Syndrome
Y	N	Scarlet Fever	Y	N	Artificial Prosthesis	Y	N	TMJ (Temporomandibular Joint) Disorder
Y	N	Sinus Trouble	Y	N	Sickle Cell Disease	Y	N	Other:_____

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

_____

DENTAL HISTORY

Previous Dentist_____Date of last visit_____

Date of last dental cleaning_____ Date of Most Recent X-Rays_____

What concerns you most about the patients' teeth? _____

Frequency of brushing:_____ Frequency of flossing:_____

Has the patient ever been shown the proper way to brush and floss your teeth? YES NO

Yes No Is the patient presently in any dental pain?_____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Has the patient ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth?_____

Yes No Sensitive Teeth? HOT, COLD, PRESSURE, SWEETS? _____

Yes No Do gums bleed when brushing? _____

Yes No Any type of thumb or tongue habit? _____

Yes No Is the patient a mouth breather? _____

Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____

Yes No What is the patient's attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result?_____

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____

Yes No Experience jaw clicking or popping? _____

Yes No Aware of clenching or grinding teeth during the day? _____

Yes No Experience "tension" headaches?_____

Yes No Has the patient ever experienced chronic ringing in the ears? _____

Yes No Does the patient need extra help with instructions? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Height of parents? Mom_____ Dad_____

Yes No Are you aware that some appointments will be during school hours?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be hazardous to my child's health.

_____ _____
Signature of patient or legal guardian Date

_____
Print Name of Legal Guardian/Parent

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following parties:

Family Member:
Name: _____

Phone #: _____

Medical Provider
Name: _____

Phone #:_____

_____
Print Name

_____
Signature of Patient

_____
Signature of Legal Guardian

If you are the legal representative of the patient, please print the patient's name(s) with DOB and describe your authority/relationship.

Patient's Name	Date of Birth	Relationship
Patient's Name	Date of Birth	Relationship