Christopher Yang DMD

Thank you for choosing our office to assist you with your dental needs!
Please fill out the information below and don't forget to provide your signature at the end.

PATIENT INFORMATION

First Name: _____ **MI**: ____ **Last Name**: _____

Preferred Name: _____ **if minor, name of legal guardian:* _____

Address: _____
Street Address Apt/Suite

_____
City State Zip

Gender: ☐M ☐F **Check One**: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Phone: ( ) **Work Phone**: ( )

Mobile Phone: ( ) **Email Address**: _____

Date of Birth: _____/_____/_____ **SS#**: _____

Employer _____ **Occupation**: _____

Emergency Contact: _____ **Relation**: _____ **Hm/Cell #**: ( )

How did you hear about our office? _____

*Our office uses text, email, and phone calls for appointment reminders and/or to discuss information regarding your care. To opt out of text and email, please check this box ☐

Person Responsible for Account (*If other than patient*)

First Name: _____ **MI**: ____ **Last Name**: _____

Address: _____
Street Address Apt/Suite

_____
City State Zip

Gender: ☐M ☐F **Check One**: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Phone: ( ) **Work Phone**: ( )

Mobile Phone: ( ) **Email Address**: _____

Date of Birth: _____/_____/_____ **SS#**: _____

Employer: _____ **Occupation**: _____

INSURANCE INFORMATION:

☐ Not covered by dental insurance – *Skip this section*

Dental Insurance Co: _____ Subscriber #: _____

Employer: _____ Group #: _____

Employee Information (*If other than patient*)

Name: _____

Date of Birth: _____/_____/_____ SS# or Member ID# _____

Please inform staff if there is additional insurance information

Name: _____ Date: _____

DENTAL HISTORY

Do you have any dental concerns? _____

Former Dentist: _____
City/State: _____
Date of Last Dental Visit: _____

Date of Last X-Rays: _____
How often do you floss? _____
How often do you brush? _____

Please check any that apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips or Mouth
- ☐ Finger Nail Biting
- ☐ Grinding
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Orthodontic Treatment (Braces)
- ☐ Periodontal Treatment
- ☐ Sensitivity to Hot/Cold
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Jaw, Head, or Neck Injuries
- ☐ Jaw Joint Clicking and/or Pain
- ☐ Tooth Pain

MEDICAL HISTORY

Physician's Name: _____ **Date of Last Visit:** _____

Are you currently under medical treatment? ☐**Yes** ☐**No** **If yes, please describe:** _____

List of Current Medications:

_____

_____

_____

Attach additional sheet if space is needed

Do you smoke, vape or use tobacco?
☐ Yes ☐No *If yes, how much*: _____

Do you use alcohol, cocaine, or other drugs?
☐ Yes ☐No *If yes, how much*: _____

Are you required to pre-medicate before dental treatment? ☐ Yes ☐No

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
☐ Yes ☐No *If yes, date*: _____

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Aspirin
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Latex
- ☐ Other: _____

For women only:

Yes	No	
☐	☐	Are you pregnant?
☐	☐	Taking hormones or contraceptives
☐	☐	Nursing

Have you had any of the following?

Yes	No	
☐	☐	Artificial heart valve
☐	☐	Previous infective endocarditis
☐	☐	Damaged valve in transplanted heart

Congenital Heart Disease (CHD) that is…

- ☐ ☐ Unrepaired, cyanotic CHD
- ☐ ☐ Repaired completely in last 6 months
- ☐ ☐ Repaired CHD with residual defects

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

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding after surgery	☐	☐	Emphysema	☐	☐	High or low blood pressure (circle one)
☐	☐	AIDS or HIV positive	☐	☐	Epilepsy or neurological disorders	☐	☐	Kidney disease
☐	☐	Allergies	☐	☐	Fainting spells/seizures	☐	☐	Mental health disorder, specify:
☐	☐	Arthritis	☐	☐	GERD/acid reflux	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Autoimmune Disease	☐	☐	Hayfever or sinus trouble	☐	☐	Severe headaches/migraines
☐	☐	Blood problems (Anemia)	☐	☐	Heart problems	☐	☐	Sexually transmitted disease
☐	☐	Blood transfusion, *if yes, date*: _____	☐	☐	Heart murmur, MVP, heart defect	☐	☐	Systemic lupus erythematosus
☐	☐	Bone or joint problems	☐	☐	Heart pacemaker	☐	☐	Tuberculosis or other lung problems
☐	☐	Cancer/chemo/radiation treatment	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Thyroid problems
☐	☐	Diabetes Mellitus ☐Type 1 ☐Type 2	☐	☐	Herpes or cold sores	☐	☐	Ulcers

Do you have any disease, condition, or problem not listed above that you think I should know about? If yes, please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient (or parent): _____ Date: _____

Signature of dentist: _____ Date: _____

1214 S 23rd St, Sheboygan, WI 53081 | P: 920-457-2410 | F: 920-457-0262

Christopher K Yang D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To summarize this form, you are giving consent for our clinic to use your information to help our office coordinate with insurance companies, other doctors who are treating you, persons responsible for your account, and/or as required by law.

This form also refers to the Notice of Privacy Practices, which lets you know how our office protects your health information and allows disclosure of your health information only with your permission and/or as required by law. Please ask our office if you have any questions.

SECTION A: Patient Information

Name: _____ DOB: _____

Additional information if not already on file:

Address: _____

Telephone: _____ Email: _____

SECTION B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent and is available at the front desk. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, the revised Notice of Privacy Practices will be available at the office front desk. You may also obtain a copy at any time by contacting:

Contact Person: Christopher Yang
Telephone: 920-457-2410
E-mail: *dental@yangdmd.com*
Address: 1214 S 23rd St, Sheboygan, WI 53081

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

Office Use Only

Patient declined to sign the Consent for Use and Disclosure of Health Information form. Staff Initials and Date: _____

--HIPAA Consent on Next Page--

Christopher Yang Dental – Patient Financial Agreement

Oral health is the foundation of our relationship and we strive to provide outstanding care for our patients.
We offer the following agreement and payment options.

For our patients with dental insurance:

We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- All patient copayments and/or patient portions are only an estimate. They are not a guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all out of pocket portions/copayments and deductibles.
- Insurance payments not paid after 45 days of billing will become your complete responsibility and must be paid in full.

For our patients without dental insurance:

Payment in full is due at the time of service, unless arrangements have been made prior to your scheduled appointment. Financing is available upon request. Please ask our office if you would like more information.

Our office honors fees for 6 months after a treatment plan is given. If any treatment has not been completed within 6 months, our fees are subject to change to the most recent fee schedule.

Statements/Finance Charges:

All patients with an outstanding balance will receive monthly statements. Balances older than 60 days are subject to collection fees and interest charges of ***1.5% per month***. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance.

Payment Options:

For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express, HSA/FSA, and CareCredit. There is a $35 fee for any checks returned due to insufficient funds.

CareCredit is available to help with patients finance larger dental or orthodontic cases. No down payment is required and payments can be made up to 6 months with no interest.

Missed appointments or short notice cancellations:

We understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice or no notice, a fee of $35 charge may be billed to your account. Please help us service you better by keeping scheduled appointments.

I understand my financial options and that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office regardless of insurance benefits. In the event my account becomes delinquent, I will be responsible for any collections, legal fees, and any other charges incurred to collect this account. I authorize Dr. Christopher Yang DMD and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand the financial agreement terms and policies and agree to follow them.

Signature of patient or responsible party: _____ Date: _____

Relationship to patient: _____
