



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	Apt/Suite	
_____	_____	_____
City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: _____	Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____	
Home Phone: (____) _____	Work Phone: (____) _____	
Mobile Phone: (____) _____	Email Address: _____	
Date of Birth: ____/____/____	SS#: _____	
Employer: _____	Occupation: _____	
Emergency Contact: _____	Relationship: _____	Contact #: (____) _____
How did you hear about our office? _____		

*Our office uses text and email for appointment reminders and to discuss information regarding your care. To opt out of text and email, please let us know or check this box

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

First Name: _____	MI: _____	Last Name: _____
Address: _____		_____
Street	Apt/Suite	
_____	_____	_____
City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: _____	Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____	
Home Phone: (____) _____	Work Phone: (____) _____	
Mobile Phone: (____) _____	Email Address: _____	
Date of Birth: ____/____/____	SS#: _____	
Employer: _____	Occupation: _____	

INSURANCE INFORMATION (SKIP THIS SECTION IF NOT COVERED BY DENTAL INSURANCE)

Dental Insurance Co: _____	Subscriber #: _____
Employer: _____	Group #: _____
Employee Information (If other than patient)	
Name: _____	
Date of Birth: ____/____/____	SS# or Member ID# _____
Please let us know if you have <u>secondary dental insurance</u> or other insurance information	

DENTAL HISTORY (TO THE BEST OF YOUR KNOWLEDGE)

Do you have any dental concerns? _____

Former Dentist: _____ Date of Last X-Rays: _____
 City/State: _____ How often do you floss? _____
 Date of Last Dental Visit: _____ How often do you brush? _____

Please check any that may apply to your oral or dental health

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Orthodontic treatment (braces) | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Jaw joint clicking and/or pain | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Jaw, head, or neck injuries | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Finger nail biting | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Grinding and/or clenching | <input type="checkbox"/> Periodontal (gum) treatment | <input type="checkbox"/> Loose teeth or broken fillings |

MEDICAL HISTORY

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

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

Current Medications:

- | | |
|--|---|
| _____ | 1. Do you smoke, vape or use tobacco?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <i>If yes, how much/often:</i> _____ |
| _____ | 2. Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <i>If yes, how much:</i> _____ |
| _____ | 3. Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Are you allergic to, or have you reacted adversely to any of the following? |
| _____ | Aspirin..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Preferred Pharmacy: _____ | Penicillin or other antibiotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Local anesthetics..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Codeine or other narcotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you take, or have you ever taken, antibiotics before dental appointments? | Sulfa drugs..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Latex..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Other: _____ |

- | |
|--|
| Have you had an orthopedic total joint replacement (hip, knee, shoulder, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>Month/Year of surgery:</i> _____ |
| Have you had any of the following? |
| Artificial heart valve..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Previous infective endocarditis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Damaged valve in transplanted heart... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>Congenital Heart Disease (CHD) that is:</i> |
| Unrepaired, cyanotic CHD..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Repaired completely in last 6 months.. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Repaired CHD with residual defects... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For women: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Taking hormones or contraceptives... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Nursing..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

- | | | |
|---|--|---|
| Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ADD/ADHD..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or neurological disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies (seasonal)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting spells/seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental health disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No | GERD or Acid Reflux..... <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Please specify:</i> _____ |
| Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Obstructive Sleep Apnea (OSA)..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches/Migraines..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems/Infections..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autoimmune Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood disease/problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur, MVP, heart defect..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe headaches/migraines..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood thinner..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually transmitted disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion, <i>if yes, date:</i> _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis, jaundice or liver disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Systemic lupus erythematosus..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone or joint problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes or cold sores..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy or Radiation Therapy.... <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |

Do you have any diseases, conditions, or problems not listed above? 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: _____

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: _____

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: _____
