FRANK SUN, D.D.S., P.C.

Family Dentistry

Patient Information

Name: _____ Preferred Nickname: _____
(Last) (First) (Middle)

Date of Birth: _____/_____/_____ Sex: ○ M ○ F Marital Status: ○ Married ○ Single ○ Child

Social Security #: _____ Driver License #: _____

Address: _____City _____Zip Code_____

Phone: (H)_____ (Cell) _____ (Work)_____

Employer: _____ Occupation: _____

Email: _____ Do you check your email regularly? ○ Yes ○ No

Have any family members been here?

○ Yes ○ No If yes, please list _____ Relationship: _____

How did you find this dental office?

○ Online ○ Newspaper ○ Referral by a friend or relatives. Name: _____

○ Dentist/Specialist Name: _____ ○ Other_____

Dental Insurance Information (Primary)

Ins. Co. Name: _____ Group #: _____ Subscriber ID # or SSN#: _____

Subscribers Name: _____ Date of Birth: _____

Employer: _____ Relationship to Patient: Spouse Parent

Address if different: _____ City _____ Zip code _____

Dental Insurance Information (Secondary)

Insurance Co. Name: _____ Group #: _____ ID # or SSN#: _____

Subscriber's Name: _____ Date of Birth: _____

Employer: _____ Relationship to Patient: Spouse Parent

Address if different: _____ City _____ Zip code _____

Dental Insurance

Your insurance benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We can generally give you an approximate estimate of your insurance benefit but, we are not responsible for any discrepancy between the estimated benefit and the actual benefit. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility from the date the service is rendered.**

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Heath problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry treatment you receive. Thank you for answering the following questions.

Please circle the appropriate answer:

Are you under a physicians care now? NO YES
Have you ever been hospitalized or had a major operation? NO YES
Do you use controlled substances? NO YES
Do you use tobacco? NO YES
Are you taking any medication? NO YES Please list: _____ _____
_____ _____

Do you require Premedication prior to dental treatment? NO YES

Are you allergic to any of the following? (please circle)

Aspirin Penicillin Amoxicillin Sulfa Drugs Codeine Acrylic Metal Latex

Local Anesthetics Others (please list) _____

Do you have, or have you had any of the following? (Please CHECK)

O Aids/HIV Positive
O Alzheimer's Disease
O Anaphylaxis
O Anemia
O Angina
O Arthritis/Gout
O Artificial Heart Valve
O Artificial Joint
O Asthma
O Blood Disease
O Blood Transfusion
O Breathing Problems
O Bruise Easily
O Cancer
O Chemotherapy
O Chest Pains
O Cold Sores
O Congenital Heart Disorder
O Convulsions
O Cortisone Medicine
O Diabetes
O Drug Addiction
O Easily Winded
O Emphysema
O Epilepsy or Seizures
O Excessive Bleeding
O Excessive Thirst
O Fainting Spells
O Frequent Cough
O Frequent Diarrhea
O Frequent Headaches
O Glaucoma
O Hay Fever
O Heart Attack/Failure
O Heart Murmur
O Heart Pace Maker
O Heart Trouble/Disease
O Hemophilia
O Hepatitis A
O Hepatitis B or C
O Herpes
O High Blood Pressure
O High Cholesterol
O Hives or Rash
O Hypoglycemia
O Irregular Heartbeat
O Kidney Problems
O Leukemia
O Liver Disease
O Low Blood Pressure
O Lung Disease
O Mitral Valve Prolapse
O Osteoporosis
O Pain in Jaw Joints
O Parathyroid Disease
O Psychiatric Care
O Radiation Treatments
O Recent Weight Loss
O Renal Dialysis
O Rheumatic Fever
O Rheumatism
O Scarlet Fever
O Shingles
O Sickle Cell Disease
O Sinus Trouble
O Spinal Bifida
O Stomach/Intestinal Disease
O Stroke
O Swelling of Limbs
O Tonsillitis
O Thyroid Disease
O Tuberculosis
O Tumors or Growths
O Ulcers
O Venereal Disease
O Yellow Jaundice

Have you ever had a serious illness not listed above? No Yes (if yes, please explain) : _____

Whom may we contact in emergency?

Name: _____ Relation to you: _____ Phone: (H)_____ (W)_____

Address: _____City _____Zip Code_____

Dental History

What is the reason for your dental visit?_____

Date of your last dental cleaning _____

Name of your previous dentist: _____ Phone: _____

How often do you brush your teeth? _____time(s)/day
How often do you floss your teeth? _____time(s)/week

Have you ever had any of the following dental treatments? (please circle)

Orthodontics (braces)	Endodontics (Root canal)	Periodontics (gums)
TMJ disorder (night guard)	Oral surgery (extraction of teeth)	Crown and/or bridge
Dentures	Implant	Biopsy
Fillings	Cosmetic dentistry (bleaching, whitening, veneer)	

Please mark the blank with a √ for Yes or No and answer all questions.

	Yes	No
Have you ever had any complications following dental treatment? …….....	___	___
Have you ever had a bad or unusual reaction to a local dental anesthetic?…….....	___	___
Have you ever had a severe injury to your face, teeth or jaws? ……..….	___	___
Are you teeth sensitive to hot, cold or pressure? ……..….	___	___
Do you have bleeding gums? ……..….	___	___
Do you have frequent or recurrent sores in your mouth? ……..….	___	___
Do you have trouble chewing or opening mouth? ……..….	___	___
Do you clench or grind your teeth? ……..……..	___	___
Do your jaw joints or muscles hurt, lock, click or pop? ……..……..	___	___
Does food get caught between your teeth? ……..……..….	___	___
Do you have any unpleasant taste or odor in your mouth? ……..….	___	___

Comments:

Authorization and Release

I certify that I have read and understand the information on this sheet to the best of my knowledge. All of the questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. . I authorize Frank Sun D.D.S. to release any information, x-rays and/or pictures including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Frank Sun D.D.S. insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on me or my dependents behalf.
I also authorized the doctor to take photographs and/or videos of my face, jaw and teeth, which will be used as a record, and maybe be used for the professional lectures, demonstrations and publications with concealing personal identity.

Signature of Patient (or parent if minor)_____ Date: _____

Authorization for Treatment and Assignment of Benefits

This will authorize the filing of any insurance in force and the direct payment to Frank Sun D.D.S. of any amount due on my claim under the above stated policy. ***I fully understand my dental policy, terms and responsibilities for the plan in which I am enrolled. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Frank Sun D.D.S for non-payment of any fees or deductibles not covered by insurance.*** I understand and agree to pay in full any balance due after an insurance payment or to make arrangements with Frank Sun D.D.S. In consideration of service rendered, the undersigned patient, spouse and/or responsible party agree to pay all cost of collections including collection agency's fees and any interest allowable by law, if incurred. The practice at its discretion may apply a billing fee of up to $10.00 per month for payments past due commencing 30 days from the date of service. The office has the right to use a collection agent if the account overdue is over 90 days. I hereby authorize the release of any dental information necessary to process claims.
I fully understand the payment policy and my financial responsibility for my dental treatment in this office. I will pay the fee in full on the day of **completion of the treatment.**

PATIENT SIGNATURE: _____ DATE:_____

_____ (Initial) I have been informed by Dr. Frank Z. Sun or Dr. Grace X. Wu of the need to undergo dental treatments as presented to me on the treatment plan. I authorize the above doctor to complete the treatments.

I have been fully informed about the details of the recommended treatments, alternatives, possible complications, my financial responsibility and my questions for my dental treatment, and agree to accept the treatments as recommended by the doctor. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I understand that as the treatment proceeds or the treatment has been completed there may be need to change the original treatment plan. If this occurs I expect to be informed before any change is instituted. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reaction during or following any treatment, I agree to report them to the office immediately and accept the necessary treatments or referral to other doctor. I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction , including oral hygiene and dietary instruction, and reporting to the office any change in my health status as soon as possible.

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES/CANCELLATION AND NO SHOW POLICY

_____ (Initial). I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices. (*Copies of the privacy policies are located at the front desk*)

PLEASE LIST ANYONE YOU ARE AUTHORIZING TO HAVE ACCESS OR DISCUSSION OF YOUR DENTAL RECORDS:
This authorization will include appointment confirmations and inquiries regarding those appointments.

NAME: _____ RELATIONSHIP _____ DOB: _____

NAME: _____ RELATIONSHIP _____ DOB: _____

_____ (Initial) I hereby acknowledge and understand there is a ***broken or cancelled appointment fee.***
I understand the treatment room will be reserved for me at the time I specified as most convenient. If for some unforeseen reason I find it is impossible to keep a scheduled appointment, I have to let the office know at least 24 hours in advance, so that another patient my be scheduled. The office reserves the right to charge at least $35.00 for appointments cancelled or broken without 24 hours advance notice. Additional fees may apply for extended appointments (over 1 hour) or a group of appointments cancelled without 24 hours notice.