Confidential Dental and Medical History

Patient's Name _____ Age_____ Date of Birth _____

Address _____ City, State, Zip_____

Home Phone _____ Cell _____

Work Phone _____ E-mail _____

Best Contact: ☐ **EMAIL** ☐ **CELL** ☐ **TEXT** ☐ **HOME** Best Time to Reach You: _____

SS# _____ Marital Status: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED**

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Do you have dental insurance? ☐ **YES** ☐ **NO** If YES, Insurance Carrier's Name _____

Group # _____ Phone _____ Subscriber's Name _____

Relation to Patient _____ Subscriber's SS# _____ Subscriber's Date of Birth _____

Employer/Co. Name _____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address,City,State,Zip _____

HOW DID YOU HEAR ABOUT US ? _____

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

Would you like to become friends with Unique Dental Care on facebook.com to receive special offers? ☐ **YES** ☐ **NO**

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Unique Dental Care 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 a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____

PRINT NAME **SIGNATURE** **DATE**

UNIQUE DENTAL CARE

540.699.2414, 2413 P

Stafford Office
556 Garrisoville Rd. Ste 208
Stafford, VA 22554

www.Uniquedentalcares.com
info@Uniquedentalcares.com

Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

	YES	NO
Have you taken any prescription drugs during the last 6 months? PLEASE LIST.	☐	☐
Are you taking any over the counter medications or herbal supplements? PLEASE LIST.	☐	☐
Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? PLEASE LIST.	☐	☐
Any surgeries and/or hospitalizations? PLEASE LIST.		
Have you ever had any excessive bleeding requiring special treatment? PLEASE LIST.	☐	☐
Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? PLEASE LIST.	☐	☐
Have you ever been told to take antibiotics prior to dental treatment? PLEASE LIST.	☐	☐

Use of alcohol: ☐ YES ☐ NO | ☐ DAILY ☐ WEEKLY ☐ MONTHLY Use of recreational drugs: ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO What type and how much per day? _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ LOW BLOOD PRESSURE	☐ KIDNEY PROBLEMS	☐ SEIZURES / EPILEPSY	☐ LEUKEMIA
☐ HIGH BLOOD PRESSURE	☐ SEXUALLY TRANSMITTED DISEASES	☐ ALLERGIES / SINUS TROUBLE	☐ BRUISE/BLEED EASILY
☐ HEART DISEASE / ATTACK	☐ ACID REFLUX	☐ ASTHMA / BRONCHITIS	☐ OSTEOPOROSIS
☐ ANGINA PECTORIS	☐ ULCERS	☐ EMPHYSEMA / COPD	☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE	☐ LIVER FAILURE	☐ CHEMOTHERAPY	☐ JOINT REPLACEMENTS
☐ HEART FAILURE	☐ HEPATITIS / JAUNDICE	☐ RADIATION TREATMENT	☐ SLEEP APNEA
☐ HEART PACEMAKER	☐ DIABETES TYPE I OR II	☐ HIV/AIDS	☐ EXCESSIVE DAYTIME SLEEPINESS
☐ STROKE	☐ THYROID / GLAND PROBLEMS	☐ ANEMIA	

Are you pregnant now? ☐ YES ☐ NO	Practicing birth control? ☐ YES ☐ NO	Plan to become pregnant? ☐ YES ☐ NO

Emergency Contact _____ Relation _____ Emergency Phone _____

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____

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Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:	YES	NO
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐

DO YOU:		
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	☐	☐
Have a hard time opening wide?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches, or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Implants
☐ Whitening ☐ Bridges ☐ Veneers ☐ Dentures ☐ Other _____

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays?_____ How often do you have dental examinations ? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric brushes, toothpick, etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

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Acknowledgment Of Receipt Of Notice Of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

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

_____

_____
PATIENT NAME

_____ _____
SIGNATURE NAME OF LEGAL GUARDIAN

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

_____

_____

****

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because _____
- ☐ Other (please describe) _____

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Cancelled and Broken Appointment Policy

Patients who fail to keep their scheduled appointments without adequate notice do cause problems for both the office, as well as other patients. We are better able to schedule you promptly and in your desired time frame if we know sufficiently in advance that you need to reschedule an appointment.We strive to schedule patients one at a time to ensure the personal attention that you deserve. We make every effort possible to remind all patients of their scheduled appointments. Please understand that this is a courtesy. **DO NOT DEPEND ON THIS**. If we are unable to reach you, your appointment confirmation text or email will serve as your confirmation of the appointment and implies your obligation to be present.In an effort to establish daily schedules that are efficient as well as considerate of your time and ours, we have adopted the following policy regarding broken and late cancelled appointment.

1. A late cancellation is defined as any scheduled appointment that a patient cancels without giving at least 48 hours advanced notice.

2. A broken appointment is any appointment which a patient fails to keep.

3. Two late cancellations may result in a charge of $50 to the patient and/or legal guardian, not covered by an insurance plan.

4. One broken appointment will NOT incur a charge, however the second one and eachone thereafter will incur a fifty dollars($50) charge for hygiene visit or Seventy five dollars($75) charge on Saturday hygiene visit. There will be one hundred dollars($100) charge per hour for Dr. Kim's time. If you are 15 or more minutes late for your appointmnet, this will be considered as a broken appointmnet.

5. Multiple late cancellations and/or broken appointments may result in your ineligibility f or future care in our office and may require a nonrefundable deposit when making an appointment.

Insurance is not responsible and will not pay for broken appointments.

We realize that circumstances sometimes arise on short notice which may result in the necessity to cancel an appointment. When such circumstances occur, we will exercise discretion in the decision to charge a fee. It is our sincere desire to be considerate of your time, and as we make every effort to do so, we hope that our patients will also be considerate of our desire to predictably serve our patients with the time available to us. Thank you for your consideration and cooperation.

Name of patient (print):_____

Signature of patient or guardian:_____Date:_____

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Financial Arrangements

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Payment:

FULL PAYMENT is due at time of service. Patients with insurance will be expected to pay their "**Estimated Patient Portion**" which is calculated based upon the information we receive from the particular insurance company. This estimated amount will be due on or before the day of service. Any balance due after the insurance has paid will be billed to the patient and due within thirty (30) days of the statement date. Unpaid balance over 60 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

» Cash, Cashier's Check, Personal Check
» MasterCard, VISA, Discover
» Patient Financing - We work with several financial organizations that will allow you to g et the treatment you need now and spread the payments over as much as 60 months, including "no-interest" programs.

Our mission is to help you to achieve the best possible dental health. Our job is to evaluate the state of your oral health and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. Your job is to determine what treatment option is best for you, and the pace at which you wish to proceed with your treatment. We will gladly respect your decisions.

The parties agree that in the event of a dispute over any payment or fee due to Dr. Sun Kim by the undersigned, the Circuit Court of Stafford County shall have exclusive jurisdiction and venue for any litigation filed by either party.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Print name **Signature** **Date**

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