

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:
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Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:
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Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:
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Home Address:	City:	State:	ZIP Code:
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Employment:	Employer's Name:	Employer's Phone: - -	Occupation:
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Employer's Address:	City:	State:	ZIP Code:
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Student Status:	School Name (if a full-time student):	Grade:
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Best places and times to contact you:	Send appointment reminders via: Text Message Email Mail
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Please tell us where you heard about us (check all that apply):

Friend or Relative (name):	Newspaper Ad	Radio Ad	TV Ad
Ad in Mail	Saw our Office	Insurance Company	Our Website
Search Engine (Google, etc.)	Other Website:		
Other:			

Was our website a factor in your decision to visit our practice? **Yes** **No**

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -
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Other family members treated by us:	Additional Comments:
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Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:	
Home Phone:	Work Phone:	Cell Phone:	E-mail Address:	
-	-	-		
Emergency_Contact Address:			City:	State: ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:
Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:	
/ /	- - -			
Home Phone:	Work Phone:	Cell Phone:	E-mail Address:	
-	-	-		
Billing Address:			City:	State: ZIP Code:
Employment:	Employer's Name:	Employer's Phone:	Occupation:	
		- - -		
Employer's Address:			City:	State: ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:		Date of Birth (mm/dd/yyyy): / /		Relationship to Patient:		Employer:	
Member ID:	Group ID:	Insurance Company Name:			Insurance Company Phone: - -		
Insured's SSN:		Insurance Company's Address:		City:		State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:		Date of Birth (mm/dd/yyyy): / /		Relationship to Patient:		Employer:	
Member ID:	Group ID:	Insurance Company Name:			Insurance Company Phone: - -		
Insured's SSN:		Insurance Company's Address:		City:		State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Chong, Sonney L DDS to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Chong, Sonney L DDS. I permit a copy of this authorization to be used in place of the original. I give Chong, Sonney L DDS, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Payment

Does the person responsible for the account already have an account with this office? Yes No

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

Cash

Check

Credit Card

Type:

Credit Card Number:

Expiration:

/

Card Verification Code:

VISA/MC/Discover: 3-digit code printed on back
AmEx: 4-digit code printed on front

Your credit card information is kept on file for outstanding account balances.

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

CareCredit

No-Interest Payment Plans

- Pay for treatment over 6 or 12 months with NO interest.
- As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase.

Low-Interest Payment Plans

- Enjoy low monthly payments with the 24, 36, 48, or 60 month extended plans.
- The 14.9% APR is lower than average credit cards and makes convenient, fixed, and low minimum monthly payments possible. This option is available for treatment fees of \$1000.00 or more. (\$5000.00 or more for the 60 month plan.)

If you choose this option, you can fill out a CareCredit application at our office.

Would you like to discuss our office's financial policy? Yes No

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a \$25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.50 for a minimum balance of \$25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a \$50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of \$25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Chong, Sonney L DDS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Chong, Sonney L DDS to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -
Address:		City: State: ZIP Code:
What did you like about your last dentist?		What caused you to leave your last dentist?

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? Yes No
What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: / Last Cleaning: /

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:		Are you interested in regular hygiene cleanings?

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?

Tooth Pain Check-up Cleaning Whitening Cosmetic Dentistry
 Sedation Dentistry Restorative Dentistry Other:

What would you like to learn more about?

Whitening Cosmetic Dentistry Sedation Dentistry Implants Bridges Veneers
 Dentures Other:

Dental Concerns

Check all that apply.

Teeth

Broken or chipped	Loose/missing filling	Missing teeth	Sensitive to sweets
Crooked	Loose teeth	Mouth sores	Blisters on lips/mouth
Decay	Tooth pain	Sensitive to cold	Orthodontic treatment
Difficulty chewing	Food trap areas	Sensitive to heat	Bad taste in mouth
Discolored	Grinding or clenching	Sensitive when biting	

Gums

Bad breath	Abscessed	Sore	Receding
Red (discolored)	Bleeding	Swollen	Periodontal treatment

Facial/Jaw Pain

Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	

Other Concerns

Smoking/dipping	Orthodontic treatment	Snoring
Biting cheeks or lip	Burning tongue	Teeth straightening
Popping/clicking	Tooth replacement	Retainer
TMJ	Fractured tooth syndrome	Dry mouth
Tooth-colored fillings	CPAP	Wisdom teeth extraction
Wisdom teeth	Implants - Tooth #:	Cosmetics
Nail-biting	Jaw locks open/closed	Smile makeover
Sleep apnea	Stain	Dental phobias
Limited orthodontics	Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Have you ever had:

Check all that apply.

Orthodontic treatment	Periodontal treatment	Your bite adjusted
Oral surgery	Your teeth ground	A bite plate or mouth guard

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -	Last Visit: /
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Address:	City:	State:	ZIP Code:
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Do we have permission to contact your doctor regarding your care? Yes No

Have you ever had:

Check all that apply.

Arthritis	Seizures	Abnormal bleeding	Recent weight loss
Arteriosclerosis	Fainting	Ulcers/colitis	Rheumatism
Birth defects	Hearing disorders	Difficulty breathing	Scarlet fever
Cancer	High or low blood sugar	Hospitalized for any reason	Sexually transmitted disease
Emotional problems	Hypotension (low blood pressure)	Emphysema	Sickle cell anemia
Head or face injury	Nervous disorder	Glaucoma	Sinus trouble
Heart murmur/trouble	Rheumatic fever	Thyroid disease	Tattoos/body piercing
History of substance abuse/drug addiction	Heart attack/stroke	Angina	TMD/TMJ (jaw pain)
Kidney problems	Heart surgery	Artificial hip/joints	X-ray or cobalt treatment
Numbness of arms or hands	Pacemaker	Gout	Yellow jaundice
Swollen, still painful joints	Artificial valves	Chest pain	Chronic fatigue syndrome
Allergies	Congenital heart defect	Circulatory problems	Cough-persistent or bloody
Asthma	Mitral valve prolapse	Cold sores	Latex sensitivity
Blood disease	Artificial bones/joints	Congenital heart lesion	Smoker
Diabetes	Shingles	Cortisone medicine	Swelling of feet/ankles
Endocrine problems	HIV/AIDS	Convulsions	Swollen neck glands
Intestinal disorders	Blood transfusions	Herpes	Tonsillitis
Hepatitis A, B, or C	Fever blisters	Leukemia	Tumor or growth on head/neck
Hypertension (high blood pressure)	Sinus problems	Excessive thirst	Easily winded
Liver problems	Sinus problems	Hay fever	Anaphylaxis
Pneumonia	Severe/frequent headaches	Heart disease	Alzheimer's disease
Shortness of breath	headaches	Hives/skin rash	Frequent diarrhea
Anemia	Cancer/chemotherapy	Hypoglycemia	Genital herpes
Bruise easily	Radiation treatments	Irregular heartbeat	Renal dialysis
Dizziness	Psychiatric problems	Lung disease	Spina bifida
Epilepsy	Tuberculosis	Osteoporosis	
	Venereal disease	Pain in jaw joints	
	Hemophilia	Parathyroid disease	

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

Acrylic	Dental anesthetics	Nitrous oxide	Tetracycline
Aspirin	Erythromycin	Novocaine	Valium
Barbiturates (sleeping pills)	Iodine	Penicillin/antibiotics	Xylocaine
Codeine	Latex rubber	Sedatives	
	Metals	Sulfa drugs	

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No

Do you take or have you taken Phen-Fen or Redux? Yes No

Do you smoke or chew tobacco? Yes No

Do you use alcohol, cocaine, or other drugs? Yes No

Do you wear contact lenses? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use more than two pillows to sleep? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

Have you been treated in a hospital in the last five years? Yes No

If female, please mark if you are:
Pregnant - If so, please enter your due date or week #:
Trying to get pregnant Nursing On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? Yes No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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For office use: Reviewed by:	Title:	Date: / /
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Oral Cancer Screening Form

Our dental practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause of increasing incidence and mortality rates of oral cancer. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases. Oral cancer risk by patient profile is as follows:

- **INCREASED RISK:** Patients age 18-39, sexually active patients (HPV 16/18)
- **HIGH RISK:** Patients age 40 and older, tobacco users (ages 18-39, any type within 10 years)
- **HIGHEST RISK:** Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

Please select one:

YES - I would like to have the oral cancer exam.

NO - I would prefer not to have the oral cancer exam at this time.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /