PATIENT REGISTRATION

Jonathan Chang, DDS, PC
Family & Cosmetic Dentistry
2301 Gallows Road, Suite 215 ~ Dunn Loring, VA 22027 ~ (703) 560-6500 ~ www.jonathanchangdds.com

PATIENT INFORMATION

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____ Social Security #:_____ Email:_____

Home Address:_____
Street Apartment #

_____
City State Zip Code

Home Phone #:_____ Mobile #:_____ Work #:_____

Employer:_____ Occupation:_____

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Other dental office
☐ Insurance directory ☐ Google/Yelp/Angie's List ☐ Other_____

Name of person or office referring you to our practice:_____

DENTAL & HEALTH HISTORY

Reason for today's visit:_____

Date and reason of last dental visit:_____

Date of last dental cleaning:_____ Date of last dental x-rays:_____

How often do you brush per day?_____ How often do you floss per week?_____

Have you had orthodontic work (braces)? ☐ Yes ☐ No

Have you had your wisdom teeth extracted? ☐ Yes ☐ No If yes, date of extraction? _____

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much per day?_____

If female, are you pregnant?..... ☐ Yes ☐ No If yes, due date?_____

Have you ever seen a periodontist (gum specialist) or have been diagnosed with gum disease? ☐ Yes ☐ No

Have you ever been diagnosed or have a family history of oral cancer? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

Do you need to *pre-medicate* before dental treatments? ☐ Yes ☐ No

Do you have an *allergic reaction* to any of the following? ☐ Yes ☐ No
(If yes, please circle below)

Aspirin Codeine Latex Metal Penicillin Sulfa Other_____

Have you ever had any of the following? Please check all that apply: ☐ **None**

☐ Arthritis	☐ Heart Murmur/Mitral Valve Prolapse	☐ Nervous Disorder
☐ Artificial Joints/Pins/Replacements	☐ Hepatitis	☐ Pacemaker
☐ Asthma/Respiratory Issues	☐ High Blood Pressure	☐ Radiation Treatment
☐ Back or neck problem	☐ HIV Positive	☐ Reaction to Anesthetic Injection
☐ Diabetes	☐ Jaw Discomfort/Pain	☐ Rheumatic Fever
☐ Dizziness/Fainting	☐ Kidney Disease	☐ Sinus Problem
☐ Excessive or Prolonged Bleeding	☐ Liver Disease	☐ Stroke
☐ Heart Disease	☐ Mental Disorder	☐ Venereal Disease

Please identify any additional information about your health that we should know about:

_____

_____

Please list any medications you are currently taking:_____

_____

_____

Emergency Contact Name: _____ Relationship to Patient:_____

Phone #:_____

INSURANCE INFORMATION

☐ No insurance

Insurance Carrier:_____Group #:_____

Subscriber Name: _____SSN / Member ID#:_____
Last First MI

Birth Date:_____Phone # (Home):_____(Mobile):_____

Employer: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If you have additional insurance, please complete the following:

Insurance Carrier:_____Group #:_____

Subscriber Name: _____SSN / Member ID#:_____
Last First MI

Birth Date:_____Phone # (Home):_____(Mobile):_____

Employer: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

OFFICE POLICY & PATIENT CONSENT/RELEASE

Please carefully review and initial each statement below.

Authorization to Release Information & Assignment of Benefits

_____I authorize the staff of Jonathan Chang, DDS, PC to take x-rays, study models, photographs, and/or other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Furthermore, I authorize treatment that is mutually agreed upon by me and the use of appropriate medication and therapy for such treatment.

_____If I have insurance, I authorize the staff of Jonathan Chang, DDS, PC to release any information concerning my health care and treatment for the purpose of evaluating and administering claims for insurance benefits. I further authorize and assign payment of insurance benefits directly to the practice of Jonathan Chang, DDS, PC, otherwise payable to me.

Appointment Policy

_____If an appointment needs to be rescheduled or cancelled, we require a ***minimum 24-hours advance notice, excluding weekends***. This allows our office to schedule other patients who are able to take your appointment time.

_____A missed appointment fee of $50 will apply (1) for appointments cancelled with less than 24-hours notice, excluding weekends; (2) if you are substantially late to your appointment; or (3) if you fail to show for your appointment. In addition, a pattern of missed appointments may result in dismissal from the practice.

Financial Policy

_____Full payment will be collected at the time services are rendered, unless previous financial arrangements have been made.

_____If you have dental insurance, your estimated co-payment will be collected at the time of service. As a courtesy, we will assist you by filing the necessary claim forms and documentation to your insurance. Once your insurance company has processed your claim, any remaining balance is the patient's responsibility. ***Please understand that having insurance is not a guarantee of coverage or payment; therefore, the patient is ultimately responsible for all charges.***

_____Any unpaid balance is subject to a monthly finance charge of 1.5% (18% annually). Should your account be turned over to a collections agency or attorney, or if a suit is instituted, in order to collect late payments, you will be responsible for the collection fees, which may be based on a percentage at a maximum 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts.

_____For any check that is returned or denied, there is an additional processing fee of $35.

_____If you are a new patient, emergency services must be paid for in cash or by credit card. Personal checks are not accepted.

I certify that the information I have provided regarding my health are true and correct to the best of my knowledge. If I have any changes to my health, I understand it is my responsibility to inform the doctor. I have also read and understand the office policies as stated above.

Signature of Patient /Guardian _____ Date _____

Printed Name _____ Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. For a complete description of the notice, please see the front desk.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Jonathan Chang, DDS, PC, and its employees to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
-Obtaining payment from third party payers (e.g. my insurance company);
-The day-to-day healthcare operations of the dental practice.

I have also been informed of, and given the right to review and secure a copy of the *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Jonathan Chang, DDS, PC, reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Please identify how you would like to be contacted for appointments, treatment and billing information:

☐ Cell Phone ☐ Text Message ☐ Email
☐ Home Phone ☐ Work Phone ☐ Any of the Above

Please identify any person(s) with whom our office has permission to share your appointment, treatment and billing information:

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature of Patient /Guardian _____ Date _____

Printed Name _____ Relationship to Patient _____