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:

☐ 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