MEDICAL HISTORY

Date_____ Referred By_____

Name_____ Email Address_____

Address_____ Apt. No._____ City/State/Zip_____

Cell Phone_____ Home Phone_____ Bus Phone_____

Date of Birth_____ Sex_____ Height_____ Weight_____ Occupation_____

Social Security No._____ Single_____ Married_____ Name of Spouse_____

Business Name_____

Insurance Company_____ Insurance Company Telephone_____

Policy, Group or Contract No._____

Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other_____

In the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

☐ YES ☐ NO 1. Are you in good health?

☐ YES ☐ NO 2. Has there been any change in your general health within the past year?

3. My last physical exam was on_____

☐ YES ☐ NO 4. Are you now under the care of a physician?

If yes, what is the condition being treated?_____

5. The name and address of my physician is _____

_____

☐ YES ☐ NO 6. Have you had any serious illness, operation, or been hospitalized?

If yes, what was the illness or operation?_____

7. Circle any of the following which you have had or now have:

AIDS	artificial heart valves	congenital heart lesions	heart murmur	HIV+	psychiatric treatment	low blood pressure
allergies	asthma	cough	heart trouble	high blood pressure	sinus trouble	rheumatic fever
anemia	cancer treatment	diabetes	hepatitis	jaundice	stroke	stomach ulcers
arthritis	cardiac pacemaker	epilepsy	herpes	kidney treatment	tuberculosis	venereal disease

other_____

8. Are you Allergic or have reacted adversely to (circle):

local anesthesia (e.g. novocaine) sulfa drugs penicillin/other antibiotics

aspirin or codeine barbituates/sedatives/sleeping pills other allergies_____

☐ YES ☐ NO 9. Are you taking any drug or medicine, including aspirin, now? if yes, list_____

☐ YES ☐ NO 10. Has you ever had Radiation Therapy or are you regularly exposed to x-rays?

☐ YES ☐ NO 11. Are you wearing contact lenses?

☐ YES ☐ NO 12. Women: Are you pregnant or nursing?

☐ YES ☐ NO 13. Have you had any serious trouble associated with any previous dental treatment?

If yes, explain_____

_____

☐ YES ☐ NO 14. Do you have disease, condition, or problem not listed above that you think I should know about?

If yes, explain_____

Chief Dental Complaint_____

_____ _____

Signature of Patient *Signature of Dentist*

CHRISTIAN CHUNG, D.D.S.

INFORMATION ABOUT YOUR DENTAL COVERAGE

The staff of Dr. Christian Chung will help you in any way we can to make sure your dental health plan reimburses appropriately for all covered services and at the correct level of reimbursement. It is important to remember that your dental health benefits are determined by your employer, your insurance company, and you. Any requirements for pre-authorization and referral and/or limitations of coverage are also determined by individuals and companies other than your dentist.

We agree to accept responsibility to provide you with any and all dental care that we deem to be necessary for your well being. You agree to accept financial responsibility for co-payments, deductibles and any dental care you agree to undergo, which are not covered by your dental health benefit plan. If dental care is rendered based on the wrong insurance plan because of inaccurate information provided by you at the time of the visit, you agree to assume all financial responsibility for those services denied.

Date_____ Patient's Name_____

Signature_____

ASSIGNMENT AND RELEASE

Name of Insurance Company _____

I assign directly to Dr. Chung all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not it is paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature_____

HIPAA PRIVACY PRACTICE INFORMATION

I, the undersigned, have been issued the HIPAA notice of privacy practices. I fully understand that Dr. Chung is required by law to maintain the privacy of my medical, dental and health information. I acknowledge that the practice will use and disclose my dental health information for purposes of treating me, obtaining payments for services rendered to me, and conducting dental care operations.

Signature of Insured/ Guardian_____ Date_____