New Patient Registration

Patient's Legal Name: ____ Preferred Name: ________________________

Date of Birth: ___________________________ Sex: Male/Female Marital Status: Single/Married/Divorced/Other

Social Security #: _________________________________ Driver's License: _________________________ State: _____

Home Address: ____ City, State, Zip: _______________________________

Telephone1: ____________________________ mobile/home/work Email: ______________________________________

Telephone2: ____________________________ mobile/home/work Preferred method: □Email □Phone □Text □Mail

If applicable: Spouse's Name: ________________________________ Spouse's Telephone: _________________________

Emergency Contact: __________________________ Relationship: ________________ Tel: ______________________

Pharmacy: ______________________ Cross Street: ______________________________ Tel: ____________________

How did you hear about us? □ Referral □ Google □ Yelp □ Yahoo □ Ins Website □ Angie's List □ Dr.Oogle □ Live nearby □ Drive by

□ If other, specify ____________________________ if referral, who may we thank: _____________________________

Dental Insurance Information: *(Please let us know if you have secondary insurance)*

Policyholder Name:		Insurance Co.	
Policyholder SSN:		Member ID #	
Policyholder Birthday:		Insurance Group #	
Relationship to Policyholder:	□Self □Spouse □Child □Other	Insurance Phone #	
Employer Name		Employer Address	

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that **failure to give sufficient warning to keep a scheduled appointment, 48 hours advanced notification, will result in a $50.00 fee being charged**. That charge which is in accordance with our dental office's broken appointment policy for all of our patients is to be paid prior to the scheduling of any new appointments. **Patient Initials:** ________

Insurance and Payment Agreement:

Our office will file insurance claims at no charge. It is the patient's responsibility to provide us current insurance information. Insurance limitations and regulations vary with all insurance plans. As a courtesy, **our staff will provide you an estimate; however, we do not guarantee your eligibility and coverage**. Therefore, if your insurance plan denies a service, you are responsible for the complete charge. I agree to pay the fees for any dental care provided by Summer Smiles Dental and Orthodontics. A finance charge of 18% annually may be applied to any overdue balance remaining after 90 days. In the event that collection procedures are necessary to collect the account, I agree to pay any attorney's fee, court costs, or collection agent fees. **Patient Initials:** ________

Patient's Signature: ____ Date: ______________________

(Parent/Guardian signature if patient is a minor)

Health History

Name: ____________________

Date: ____________________

Please check all applicable Dental concerns:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Lip or cheek biting
- ☐ Discolored Tooth
- ☐ Chew on one side of mouth
- ☐ Dry mouth
- ☐ Blisters on lips or mouth
- ☐ Fingernail biting
- ☐ Foreign objects
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Pain around ears
- ☐ Crooked teeth
- ☐ Periodontal treatment
- ☐ Sensitivity ___hot ___ cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Ortho treatment
- ☐ Swollen or tender gums
- ☐ Silver fillings
- ☐ Other: ______________________

Reason for this visit: ____

Medical History:

Do you have or have you had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joint/Prosthesis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer/Tumor
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epstein-Barr
- ☐ Fainting/Dizzy Spells
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack [date] ______
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Heart Valve Replacement
- ☐ Hearing Disorders
- ☐ Hepatitis type ______
- ☐ Herpes
- ☐ High/Low Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Pain in Jaw Joints
- ☐ Persistent Cough
- ☐ Psychiatric Care
- ☐ Radiation/Chemo
- ☐ Rheumatism
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ STD or VD
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Tobacco Habit:
  Qty per day ________

☐ Other disease/condition/treatment: ____

Women: Are you pregnant: ☐ Yes ☐ No, if yes, due date: _______________ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you ever taken bisphosphonates? (ex: Actonel, Aredia, Boniva, Didronel, Fosamax) ☐ Yes ☐ No, if yes name: ______________________

Have you ever or are you taking any of these drugs? Circle ones that apply: Cortisone, Steroids, Blood thinners

Have you ever taken weight loss products? (ex: Phen-Fen, Redux) ☐ Yes ☐ No, If yes name: ____

Medications	Allergies
List drug, medicine or herbal supplement you are currently taking: ____ ____ ____	☐ Aspirin ☐ Local Anesthetic ☐ Barbiturate [sleeping pills] ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Iodine ☐ Skin reaction to metal ☐ Other ________________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Sean Hsia of any change in my health and/or medication. I consent to taking radiographs, study models, photographs, or any other diagnosis aids deemed appropriate to make thorough diagnosis of the patient's dental needs.

Patient's Signature: ____ Date: ____________________

(Parent/Guardian signature if patient is a minor)

Consent for Use and Disclosure of Health Information

Patient Name: ____ Social Security #: _____________________

Please list the names of ALL the people you authorize us to release your health information to, including copies of your

records if needed: ____

Patient Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice, at any time by contacting us.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Patient's Signature: ____ Date: _____________________
(Parent/Guardian signature if patient is a minor)