Authorization and Consent to send Unencrypted Patient Information by Email and other Electronic Means

Until I tell you in writing to stop S.Y Dentistry DMD, PC to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or S.Y Dentistry DMD, PC health care operations. The patient information that may be emailed may include my X-Rays, health history, diagnosis, treatment, and payment records.

I understand that:

- **I do not have to sign this form**
- **My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form**
- **If I do not sign this form S.Y Dentistry DMD, PC may use other ways to send my information such as, U.S Mail, or may ask to send my information to third parties myself.**
- **There is more risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be disclosed and no lower protect my privacy law.**
- **SY Dentistry DMD, PC does not email such as sensitive personal information as Social Security number, Credit Card, Mental Health Diagnosis, Genetic Information, alcohol/substances abuse, or positive HIV status unless the patient insists.**

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that S.Y Dentistry DMD, PC already sent before receiving my written instructions to stop.

Patient Name (Please Print): ____

Signature: ____ Date: ________________

Acknowledgement of Receipt of Notice of Privacy Practices

Shurlang Yen D.M.D

Family Cosmetic Dentistry

You May Refuse to sign this Acknowledgement

I have received a copy of this office Notice of Privacy Practices.

Print Name: ____

Signature: ____

Date: ____________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not obtain because:

- Individual Refuse to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

  ____

  ____

  ____

  ____

Financial Agreement

I,_____________________ understand that I am personally responsible for all charges I incur as a patient of S.Y. Dentistry, DMD, PC ("Dr. Yen"), regardless of any insurance coverage I may have. I also understand that my insurance coverage is a contract between myself and my insurer, and that in the event of non-payment, I will be held responsible for my balance, not my insurance company.

I understand that S.Y. Dentistry, DMD, PC will gladly file the patient insurance claims in instances where the practice participates in the patients insurance company's network. All estimated patient financial responsibility is due at the time of the service of any procedure. We will allow insurance companies a reasonable amount of time to pay on a claim (usually ninety days). After this reasonable period of time has passed without payment, the balance will be billed to the patient for payment.

Further, in the event of non-payment, I understand that I will bear the cost of collection and/or court costs and reasonable legal fees should this be required to collect the balance of my account. Should my account be turned over to a collection agency, the collection agency's fee will be added to my balance for collection.

I understand that S.Y. Dentistry, DMD, PC charges patients $25.00 for returned checks.

Important: Please understand that we strive to provide you with a most current and accurate estimate based on your dental needs. Benefits quoted are only an ESTIMATE!

Patient Signature or Legal Guardian: __________________________

Date: ____________________

Late Cancellation or Missed Appointments

Our office reserves time for your appointment with the Doctor. When you have a reserved time with our providers of care and do not keep your appointment there is a late cancellation $50 charge. This charged is billed to you if you have cancelled less than 24 hours prior to your appointment. We of course understand there are emergencies or illness and know that this cannot be planned upon – this will always be taken into consideration.

I have read and acknowledge the policy above:

Patient/Guardian Signature ____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name: ____
Phone #: (____) ____ Date of last visit: ____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: ____
Do you smoke or use tobacco in any other form? ☐ Yes ☐ No
Have you had any metal rods, pins or implants? ☐ Yes ☐ No
Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No
Please list each one: ____
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No
Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: ____
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding / Hemophilia
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Heart Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV +
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:
____
____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: ____
____

5 DENTAL HISTORY

Why have you come to the dentist today? ____
____
Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No
Type of bristles on your toothbrush? Hard ☐ Medium ☐ Soft
Have you ever had gum treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold, or anything else? ____
Do you have any loose teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? ____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

____
Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: ____ Date: ____

Doctor's Comments: ____
____
____
____
____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ____

Patient Signature Date
Dentist Signature Date

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ____

Patient Signature Date
Dentist Signature Date

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Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date:______________

E-mail Address: ______________________________

Name: ______________________________
Last First Mi Mr Mrs Ms Dr

I prefer to be called:______________ ☐ Male ☐ Female

Birthdate:____/____/____ Age: ____ SS#: ______________

Home Address: ______________________________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____)____________ Cell #: ______________

Wk #: (____)____________ Ext:____ DL #: ______________

Employer: ______________________________

Employer's Address:______________________________

____
City State Zip

How long there? ________ Occupation: ______________

Where & when are best times to reach you? ______________

Whom may we Thank for referring you? ______________

Other family members seen by us: ______________

Previous / Present Dentist: ______________
(Please Circle)

Person Responsible for Account:______________

3 SPOUSE INFORMATION

His / Her Name:______________________________

Employer:______________________________

Contact #: (____)____________ Ext:____ SS #: ______________

Birthdate:____/____/____ DL #: ______________

Relative or Friend not living with you (for emergency).

His / Her Name:______________ Relation: ______________

Contact #: (____)______________________________

2 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #):______________

Insured's Name:______________ Relation: ______________

Insured's Birthdate: ____/____/____ Insured's ID #: ______________

Insured's Employer: ______________________________

Employer's Address:______________________________

____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #):______________

Insured's Name:______________ Relation: ______________

Insured's Birthdate: ____/____/____ Insured's ID #: ______________

Insured's Employer: ______________________________

Employer's Address:______________________________

____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

CONTINUED ON BACK