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 _____

Dental & Medical History

Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or supplement drugs that the child is currently taking:

_____

_____

Aside from the items listed, please list all drugs/things that the child is allergic to:

_____

Y N Latex Y N Metals/Nickel Y N Plastic

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hepatitis
Y	N	Anemia	Y	N	Hives/Skin Rash
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asperger's Syndrome	Y	N	Low/High Blood Pressure
Y	N	Asthma	Y	N	Lupus
Y	N	Autism	Y	N	Measles
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Chicken Pox	Y	N	Mononucleosis
Y	N	Congenital Heart Defect	Y	N	Prosthetics
Y	N	Convulsions	Y	N	Rheumatic Fever
Y	N	Covid-19	Y	N	Scarlet Fever
Y	N	Diabetes	Y	N	Sickle Cell Disease
Y	N	Epilepsy	Y	N	Stroke
Y	N	Exposed to HIV, but Neg.	Y	N	Tuberculosis (TB)
Y	N	Handicaps/Disabilities			

Are the child's immunizations current? ☐ Yes ☐ No

Has this child received Covid-19 vaccination? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

_____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

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.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

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

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

WELCOME!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

_____
City State Zip

Parent's Information

Who is responsible for account? _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Parent: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

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

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

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

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

CONTINUED ON BACK