Ellis C. Wong D.D.S. Inc

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Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Our Dental Office sends Appointment reminders via text and email. By checking the boxes below you are consenting to receive email or text reminders when your scheduled appointment is approaching.

Please check below what your preferences are.

☐ Call Me ☐ Text Me ☐ Email Me

Please call the office if your contact information needs updating! _____

Whom may we thank for referring you to our practice? _____

Dental Information

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb
☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted
☐ Had any teeth removed

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

When was your last Dental visit? _____

Primary Dental Insurance:

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____-_____

City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I authorize the office to save a credit/debit card so that it may be used for charges not paid by insurance.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Consent for Credit Card on file and Financial Policy

As a condition of treatment by this office, financial arrangements MUST be made in advance.The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment

☐ **By checking this box, I am giving the office permission to save a credit card on file and to charge that card to collect any outstanding balance on my account.**

☐ * **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

Office Policy

This time we have reserved for your appointment is critical to enable us to attend to your specific needs.

We will call you at least two days prior to your appointment to reconfirm. In the event that we are unable to reach you directly and must leave a message to remind you, it is IMPERATIVE that you call us back and speak with one of our staff members, or leave a message on our voicemail after hours, confirming your appointment time. If you do not respond by 8 am the day prior to your appointment, we will cancel your scheduled time, and it will be given to another patient who is in need of care.

Please be advised that there will be a $50 charge for any appointment that is not cancelled or rescheduled with 24 hours prior notice.

Thank you for your cooperation and understanding.

☐ **By checking this box, I acknowledge that I have read this statement and agree to the policy.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

We can supply a copy of the HIPPA Policy to you

◯ Yes, I'd like a hard copy ◯ Yes, I'd like a copy emailed to me ◯ No, I don't want a copy

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature _____ **Date** _____

Response Date: _____