ROGER HO DDS
General & Cosmetic Dentistry

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email address _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced

If college student, F.T/P.T., name of school _____ City _____ State _____

Employer _____ Work phone _____

How did you hear about us? ☐ Friend/ Family ☐ Insurance ☐ Yelp ☐ Mailer ☐ Other

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party ☐ Myself

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Phone number _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of primary subscriber _____ ☐ Myself Relationship to patient _____

Primary subscriber's birthday _____ Soc. Security # _____

Name of employer _____ Work phone _____

Name of Dental Insurance _____ Tel. # _____ Grp. # _____

Policy/I.D.# _____ Insurance effective date _____

Do you have any additional insurance ☐ Yes ☐ No If yes, Name of your dental insurance

Name of primary subscriber _____ DOB _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT *(or parent if minor)* **DATE**

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HEALTH HISTORY

Patient Name: _____ **Birth Date:** _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam? _____ Date of last Dental exam _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Family history of diabetes, heart problems, tumors?
39. Yes No Allergies to: ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Other: _____
40. Yes No AIDS, HIV?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries? _____
59. Yes No Pacemaker?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

LIST OF MEDICATIONS: _____

_____

_____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:

_____

To the best of my knowledge, I have answered every question completely an accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

I have received a copy of "Notice of Privacy Practices" from **Roger Ho, D.D.S. Inc**. This Notice of Privacy Practices presents the information that federal law requires us to give our patients regarding our privacy practices.

*Signature*_____ *Date*_____

DENTAL INSURANCE

There are over thousands of dental insurance plans. We do our best to help you understand your insurance coverage. Dental policies can change every year when contracts renew. Change in eligibility and benefits could result in unexpected out of pocket cost. **We encourage our patients to become familiar with their insurance coverages.**

At our dental office, we gladly submit your insurance claims for you and will fully attempt to help you receive full insurance benefits. **Patients are responsible for payments of the services provided. An insurance policy is a contract between you, your employer, and the insurance company.** We have no direct relationship with the insurance companies.

TEXT MESSAGE NOTIFICATION

Your health care is important to us. In order to provide you with the best possible care, you will **receive text messages for appointment reminders and information about your dental treatments.** If you wish to opt-out of all SMS communications, please inform the front office personnel. Thank you!

*Signature*_____ *Date*_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the new notice available upon request.
You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose you health information t obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On you Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with n opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable interferences of our best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of you location and general condition.

Appointment Reminders: We may use of disclose you health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use of disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit.

- As required by :
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related ill or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state workers compensation laws.

QUESTIONS AND COMPLIANTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

- We may have violated your privacy rights.
- We made a decision about access to your health information incorrectly
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect or
- We should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written compliant to the U>S> Department of Health and Human Services. We will provide you with the address to file our compliant with the U>S> Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U>S> Department of Health and Human Services.

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