NEW PATIENT INFORMATION: ADULT

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YAP FAMILY DENTAL

PATIENT'S NAME (FIRST MI. LAST): _____
Preferred Name: _____ Sex: ☐Male ☐ Female
Birth Date: _____ /_____ /_____ SSN#_____

Marital Status: ☐Single ☐ Married – Spouse's name _____

Email Address: _____

Home Address: _____

City: _____ State:_____ Zip:_____

Cell#:(_____)_____ TEXT OK? ☐Yes ☐No

Home #:(_____)_____ Work #:(_____)_____

Occupation: _____

Employer (or School): _____

Employer (or School) City: _____

Are you the primary subscriber of a dental insurance plan? ☐Yes ☐No

Insurance Carrier Name: _____Group/ID #:_____

Plan Address: _____

City: _____ State:_____ Zip:_____

IS ANOTHER PERSON RESPONSIBLE FOR THE ACCOUNT?
IF YES, PLEASE FILL OUT BELOW. IF NO, SKIP THIS SECTION

FIRST MI. LAST NAME: _____

Relation to Patient: ☐ Spouse ☐ Parent ☐ Other _____

Birth Date: _____ /_____ /_____

Email Address: _____

Address (IF DIFFERENT): _____

City: _____State:_____ Zip:_____

Phone #:(_____)_____☐Cell ☐Home ☐Work

Occupation: _____

Employer: _____City: _____

Is the patient covered under your dental insurance plan? ☐Y ☐N

Insurance Carrier Name: _____

Group/ID #:_____ SSN #_____

Plan Address: _____

City: _____ State:_____ Zip:_____

EMERGENCY CONTACT
Please list the nearest relative/friend not living with you:

Name(s): _____ Relationship to patient: _____

Home Telephone #:(_____)_____ Work #:(_____)_____ Cell#:(_____)_____

HEALTH PROVIDERS

Name of Physician: _____ Phone#: (_____)_____

Address: _____ City: _____ **Kaiser Medical #** _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

☐ Friend/Co-worker/Family (NAME) _____ ☐ Google ☐ Facebook ☐ Yelp ☐ Other _____

DENTAL HISTORY

What is the primary reason for your visit today? _____

Date of last visit to the dentist: _____ Date of last x-rays _____ Date of last cleaning _____

Name of previous dentist: _____ Phone#: _____City: _____ State:_____

What, if anything, has happened in previous experiences at the dentist that gave you reason not to return?

_____

Have you ever had any serious problem associated with previous dental treatment or any dental emergency? Y N

If yes, describe: _____

Are you apprehensive about dental treatment? Y N If yes, explain_____

What, if any, would prevent you from having dental treatment? (RANK IN ORDER #1 -4; #1 *BEING THE PRIMARY REASON*)

_____ Fear of Pain/Discomfort _____Cost of Treatment _____Lack of Concern _____Missing Work Time

DENTAL HEALTH:

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any of the following conditions?

Sensitivity to hot or cold	Y	N	Gums bleed frequently	Y	N
Sensitivity to pressure/when biting	Y	N	Jaw clicks or pops or soreness	Y	N
Avoid chewing on one side	Y	N	Snoring	Y	N
Bad breath	Y	N	Missing/loose teeth	Y	N
Clench or grind teeth	Y	N	Blisters on lips or mouth	Y	N
Dry mouth/excessive thirst	Y	N	Sores/Growth inside mouth	Y	N
Food collection between teeth	Y	N	Anxiety about dental treatment	Y	N
Gums swollen or tender	Y	N	Other_____		

Have you had any of the following treatments?

Orthodontic treatment (braces)	Y	N
If yes, what age? _____		
Periodontal (gum treatments)	Y	N
Wisdom Teeth extracted?	Y	N
Dental Implants	Y	N
Night guard (occlusal guard)	Y	N
CPAP	Y	N
SnoreGuard or Sleep Appliance	Y	N

PLEASE COMPLETE OTHER SIDE

Patient Name:

DENTAL HYGIENE

How many times a day do you brush your teeth?
☐ 0-1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

How often do you **floss**? ☐ never/rarely ☐ at least 2x/wk ☐ every

What kind of Toothbrush do you use?
☐ Standard manual toothbrush
☐ Sonicare ☐ Oral-B Electric ☐ Other Electric_____

DENTAL AESTHETICS

How do you feel about the appearance of your teeth? ☐ Great ☐ Good ☐ Okay ☐ Not so good ☐ Horrible

If you could change anything about your smile, what would you change? ☐ healthier ☐ whiter ☐ straighter ☐ other (specify below)

_____

PATIENT RESPONSIBILITIES

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

FINANCIAL RESPONSIBILITY

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, check, and any major credit card. Third-party financing is also available through CareCredit (www.carecredit.com).

_____ INITIAL I understand and acknowledge that I am financially responsible for the services provided for myself regardless of insurance coverage, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received within 60 days, I understand that a 1.5 % finance charge (18% APR) will be added to my account, including at $5 late fee, in addition to any collection charges.

DENTAL BENEFIT PLANS

Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. We ask that you notify us with any changes to your employment or dental benefits.

_____ INITIAL **Financial Responsibility & Assignment of Benefits:** I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist/practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize direct payment of the dental benefits otherwise payable to me, to Andrew W. Yap, DDS.

_____ INITIAL **Release of Information:** To the extent permitted by law, I consent to the use and disclosure of my protected health information, including my signature and social security number, to carry out payment activities on all insurance submissions.

PATIENT INFORMATION AND PATIENT RIGHTS

_____ INITIAL **Facts about Fillings:** I have been given the opportunity to read and ask questions about "The Facts About Fillings," a dental material fact sheet providing information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

_____ INITIAL **Privacy Notification:** I acknowledge that I have been given the opportunity to read and ask questions about this practice's "Notice of Privacy Practices," which describes how my information may be used or disclosed.

_____ INITIAL **Patient Records:** I understand that I have a right to request a copy of my dental records . I authorize the release of a portion or all of these records which are deemed useful for the diagnosis, treatment or consultation regarding my dental health, to other dental providers, dental specialists, and medical providers. I authorize the transmission of these records via e-mail and understand that there may be charges related to the duplication of xrays, should I request hardcopies.

COMMUNICATION regarding your ACCOUNT and APPOINTMENT

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this commitment, when a patient cancels an appointment or is more than a few minutes late, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. **With less than 48-hour notice, a fee/deposit of $40, may be required to reserve your next appointment.** In addition, we ask that our patients be on time or call in advance.

_____ INITIAL I understand the scheduling policy and that I will be asked to confirm each and every appointment and can do so via phone, text or email.

_____ INITIAL I consent to the dental practice using my cell phone number to text or call regarding appointments, treatment, insurance, and my account. I can opt-out at any time.

_____ INITIAL I consent to the dental practice using my email address regarding appointments, treatment, insurance/payments, and my account. I can opt-out at any time.

CONSENT FOR TREATMENT

I authorize the dentist and his staff to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of my dental needs. I understand that some of these images may be used by dental insurance carriers to determine benefits and by dental laboratories for the fabrication of crowns, veneers, bridges, dentures or other appliances and that these images will become a part of my permanent dental record. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, office website, or advertisements for the purposes of advancing medical-dental education and/or promoting cosmetic dentistry. I do not expect compensation, financial or otherwise, for the use of these images.

I also authorize dentist to perform all recommended treatment mutually agreed by me and to use the appropriate procedures, medication, anesthetics and therapy indicated for such treatment. I understand that using anesthetic agents embodies certain risk.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my health and/or medication. Further, I will not hold the dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date_____

If this consent is signed by a personal representative on behalf of the patient:

Personal Representative's Name: _____Relationship to Patient _____

_____
Reviewed by Dentist

Date _____