ROY H. PARK DDS
Dentistry With a Caring Touch

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www.royparkdss.com

Welcome to our practice! Our goal is to provide you with the best care so please help us in doing so by completing all **four** forms. All information is completely confidential. We look forward to seeing any friends or family you refer to our office. **Thank you!**

Patient Information

Name (Last, First, Middle):_____Date:_____
Nickname:_____DOB:_____Age:_____Sex: □Male □Female
Social Security Number:_____Marital Status:_____Email: _____
Home Phone:_____Cell Phone:_____Work Phone: _____
Address:_____City:_____State: _____Zip Code:_____
Employer:_____Occupation:_____Employer Phone: _____
How did you hear about us?□Online or □Live in the area or □Referred By: _____
Emergency Contact Name and Phone Number: _____

Dental Insurance

Account Holder Name:_____DOB:_____Relationship to Patient: _____
Social Security or Member ID Number:_____Phone Number: _____
Employer:_____□ Full Time □ Part Time □ Retired
Insurance Company:_____Group Number:_____Phone:_____
Address:_____City:_____State: _____Zip Code: _____ **Do you have a secondary insurance? Circle: Yes No**

Account Holder Name:_____DOB:_____Relationship to Patient: _____
Social Security or Member ID Number:_____Phone Number: _____
Employer:_____□ Full Time □ Part Time □ Retired
Insurance Company:_____Group Number:_____Phone:_____
Address:_____City:_____State: _____Zip Code: _____

Dental History

What is the reason for your visit today? _____
Previous Dentist:_____Date of Last Cleaning:_____Date of Last X-Rays:_____
Are you feeling sensitivity to hot/cold/pressure?□Yes □No Explain: _____
Are you experiencing jaw pain/clicking/popping around ears? □Yes □No Explain:_____
Are you having difficulty opening/closing of your mouth? □ Yes □No Explain: _____
Are you having difficulty chewing on either side of your mouth?□Yes □No Explain: _____
Do you smoke, chew tobacco, or vape? □Yes □No Please specify which, how long, and often: _____
_____
Do you have a family history of: □Oral Cancer □Gum disease □Excessive cavities □Not sure
Are you satisfied with the appearance of your teeth? □Yes □No
Are you interested in whitening? □Yes □No

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Medical History

Physician_____Office Phone_____Date of last physical _____

1. Are you under medical treatment now? □Yes □No Reason_____

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?□Yes □No Reason

__

3. Do you need to be **PREMEDICATED** before dental treatment?□Yes □No Reason_____

4. Have you ever taken prescription medication for weight loss (e.g. Fenphen, Redux)?□Yes □No

5. Have you ever used **bisphosphonate** medication? (e.g. Fosamax, Actonel, Boniva, Prolia)□Yes □No

6. Are you currently taking **blood thinners**, including aspirin? □Yes □No If yes please list name, reason, and dosage:_____

7. If not answered above, are you taking any medication, drugs or pills now (including regular doses of vitamins, herbals and homeopathic meds)?□ Yes□ No If yes, list name, dosage and reason:

_____

_____

_____

8. Are you **ALLERGIC** to or have had an adverse reaction to any of the following? □Aspirin □Codeine □Local anesthetic (e.g. Novocaine) □Penicillin or other antibiotics □Sulfa drugs □Latex Other_____

9. Please **circle** **"Yes"** or **"No"** to indicate if you have had any of the following:

AIDS/HIV Positive	Yes	No	Heart Murmur	Yes	No
Anemia	Yes	No	Heart Pacemaker	Yes	No
Arthritis/Rheumatism	Yes	No	Hepatitis (Type:_____)	Yes	No
Artificial Heart Valves	Yes	No	High Blood Pressure	Yes	No
Artificial Joints(Year?_____)	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bleeding Abnormally	Yes	No	Low Blood Pressure	Yes	No
Cancer	Yes	No	Mitral Valve Prolapse	Yes	No
Chemical Dependency	Yes	No	Pacemaker	Yes	No
Chemotherapy	Yes	No	Psychiatric Care	Yes	No
Chest Pain	Yes	No	Radiation Therapy	Yes	No
Congenital Heart Lesions	Yes	No	Rheumatic Fever	Yes	No
Cortisone Treatments	Yes	No	Sinus Trouble	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Emphysema	Yes	No	Swollen Feet or Ankles	Yes	No
Epilepsy or Seizures	Yes	No	Thyroid Problems	Yes	No
Fainting or Dizzy Spells	Yes	No	Tuberculosis	Yes	No
Freq Heartburn/Reflux/GERD	Yes	No	Ulcers	Yes	No
Glaucoma	Yes	No	Unexplained Weight Loss	Yes	No
Hay Fever	Yes	No	Venereal Disease	Yes	No
Heart (Surgery, Disease, Attack)	Yes	No			
WOMEN: Are you pregnant?	Yes	No	Due date _____		
Taking birth control pills?	Yes	No	Nursing	Yes	No

10. If you have any disease, condition, or problem not listed above, please explain:_____

I understand the above information is necessary to provide me dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or facility, who may release such information to you. I will notify the doctor of change in my health or medication.

x_____x_____Date_____

Print patient name (or parent if minor) Signature of patient (or parent if minor)

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HIPPA Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, as well as the uses and disclosures we may make of your protected health information or other important matters pertaining to your health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes many apply to any of your protected health information that we maintain.

Consent will not affect any action we took in relying on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I,_____(print name) have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

x_____ Date_____
Signature of patient (or parent if minor)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment count not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify below)

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize this dental practice to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical or dental information for this or any related claim, to my insurance carrier. A copy of the authorization may be used in place of the original.

Either my insurance carrier or I may revoke this authorization at any time in writing.

x_____ _____

Signature of patient, insured or beneficiary Date

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all dental insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this dentist for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization maybe used in place of the original.

x_____ _____

Signature of patient, insured or beneficiary Date

FINANCIAL AGREEMENT

I hereby assume financial responsibility for and agree to make payment in full to Roy H. Park, DDS, for all charges for services or dental supplies furnished the above named not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days of receipt of the statement, unless payment arrangements are made with the business office. I certify that the financial information given is true, accurate and complete, to the best of my knowledge, and further authorize Roy H. Park, DDS to investigate any and all financial information concerning this or related claims.

x_____ _____

Signature of patient, insured or beneficiary Date

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.