Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment # City State Zip Code

E-Mail Address: _____ Name of person referring you: _____

Employer Information

Employer Name: _____ Occupation: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Social Security #: _____ Birthdate: _____ ☐ Male ☐ Female

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment # City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Policy of Care and Payment

Initial

_____**As a condition of your treatment plan by this office, financial arrangements must be made in advance.** Michael S Cho DDS, General Dentist requires payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, cash and check. If you are in need of an extended finance option, we also work with **Lending Club.**

Initial

_____**Insurance:** You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment.

Initial

_____**Missed Appointment/Late Cancellation:** Please give us the courtesy of 48 hours notice if you are unable to make your appointment. If adequate notice is not given, a Missed appointment/Late Cancellation charge will be applied to your account in the amount of $50.00 for each hour of time scheduled.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Dental History

So that we may provide you with the best possible care please complete this dental history form
All information is completely confidential

1. What is the reason for your visit today?_____
2. Date of last dental visit_____Last cleaning_____
3. Name of your previous dentist_____
4. How often do you brush your teeth?_____How often do you floss?_____
   What other dental aids do you use (Sonicare, Oral B, electric toothpicks)
5. Do you have any dental problems now? Yes No
   If yes, please explain_____

6. Are any of your teeth sensitive to:
   - Hot or cold? Yes No
   - Sweets? Yes No
   - Biting or chewing? Yes No

   Have you noticed any mouth odors or bad tastes? Yes No

   Do you frequently get cold sores, blisters or any other oral lesions? Yes No

7. Do your gums bleed or hurt? Yes No
   Have your parents experienced gum disease or tooth loss? Yes No
   Does food tend to become caught in between your teeth? Yes No

8. Do you:
   - Clench or grind your teeth while awake or asleep? Yes No
   - Bite your lips or cheeks regularly? Yes No
   - Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
   - Mouth breathe while awake/asleep? Yes No
   - Have tired jaws, especially in the morning? Yes No
   - Smoke or chew tobacco? Yes No

9. Have you ever had:
   - Orthodontic treatment? Yes No
   - Oral surgery? Yes No
   - Periodontal treatment? Yes No
   - Your teeth ground or the bite adjusted? Yes No
   - A bite plate or nite guard? Yes No
   - A serious injury to the mouth or head? Yes No
     if so, please describe, including the cause_____
     _____

10. Have you ever experienced:
    - Clicking/popping of the jaw? Yes No
    - Pain (joint,ear,side of face) Yes No
    - Difficulty opening/closing Yes No
    - Difficulty chewing? Yes No
    - Headaches, neck aches or shoulder aches? Yes No

11. Is it important to you to keep all of your teeth? Yes No
12. Do you feel nervous having dental treatment? Yes No
13. Have you ever had an upsetting dental experience? Yes No
    Describe_____
    _____
    _____

14. Is there anything else about having dental treatment that you would like us to know? Describe:

Name_____Date_____

Time 6:12 PM | Michael S Cho, DDS, PS | Date 6/19/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Please read and initial the following statements_____

Scheduling Policy: While Dr. Michael S. Cho DDS PS will make every effort to accommodate our patients' busy schedules, our policy is to reschedule any patient arriving late for an appointment, so as not to inconvenience others for whom we have reserved time. In these situations, we may shorten or reschedule the appointment, dependent upon the time we have reserved for others that day.

Initial_____

Cancellation Policy: We require two working days' notice (48 hours) to reschedule or cancel dental appointments. For each hour reserved for you, a charge of $95 will be assessed for late appointment charges or for failure to keep an appointment. Please respect our other patients' time by informing us as soon as possible when you are unable to make an appointment.

Initial_____

Estimation of Dental Benefits: I understand that Dr. Michael S. Cho DDS PS can only provide an estimate of dental insurance benefits and cannot guarantee payment by my insurance company. It is in my best interest to understand my benefits as coverage varies from plan to plan (even with the same company). If I request, Michael S. Cho DDS PS will submit a predetermination of benefits to my insurance company prior to beginning treatment. If my account should be placed in the hands of an attorney for collections or if suit shall be brought to collect any of the principal, interest or monthly billing fee of this account, I promise to pay reasonable attorney's fees and cost of such suit.

Initial_____

Photography: I understand that as a part of my care, photographs may be taken of my teeth and face. The publication or showing of these photographs will be for insurance related, educational and healthcare operations only.

Initial_____

Notice of Privacy Practices: I have received a copy of the Notice of Privacy Practices.

Initial_____

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to Michael S. Cho DDS PS. I am responsible for payment of my account even though an insurance claim has been filed. To the extent permitted under applicable law, I authorized Michael S. Cho DDS PS to release information relating to the claim. I am responsible for the portion not covered by insurance on the day of my appointment.

Initial_____

Patient Signature_____Date_____

Financial Policy Agreement

Outstanding Patient Service is Our Goal

The goal of Dr. Michael S. Cho DDS PS is to make sure you receive the highest quality dental care and service. One step towards that goal is to make certain that our financial policies are clear and understood by you, our patient.

Insurance – We Go the Extra Mile

If you have insurance, we will make a good faith estimate of your benefits. We will take care of completing and filing the appropriate claim forms with your insurance provider. We will also track your claim and make sure that it is paid in a timely manner. We are also happy to provide your insurance x-rays or other information they may require.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot compel your insurer to pay.

Payment Due at the Time of Treatment

Fees for services are due at the time of treatment after deduction of your good faith estimate of insurance benefits.

Payment Options

We accept cash, check, Visa, MasterCard, Discover and American Express. If you require a deferred payment option we offer Care Credit. If you would like to take advantage of this deferred payment option, please ask for the short and simple application. Approval takes only a few minutes.

Your Responsibility

I acknowledge my responsibility for payment of services received from Dr. Michael S. Cho DDS PS in accordance with their regular fees and terms.

I understand that this account becomes delinquent if not paid within 60 days after the date of service and that at that time a billing fee of $15.00 will be charged every month until the balance is paid in full.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any health care information requested by my insurance carrier.

Patient
Signature_____Date_____

Staff member initials _____Date_____

Dr. Michael S. Cho DDS PS 3216 NE 45th Pl, Ste 305, Seattle, WA 98105 206-522-0466

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Michael S. Cho.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship

This form will be retained in your dental record.

Dr. Michael S. Cho DDS PS 3216 NE 45th Pl, Ste 305, Seattle, WA 98105 206-522-0466