

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.

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

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 _____

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



UNION BAY DENTAL CARE

MICHAEL S. CHO, DDS

Union Bay Dental Care

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. By signing this consent, you acknowledge that you have reviewed our notice prior to signing.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree to requested restrictions, but if we do, we will honor them.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows the use and disclosure of information for treatment, payment, and healthcare operations.

Additional Federal Confidentiality Protection for Substance Use Disorder Records:

Some protected health information may include records related to substance use disorder (SUD) diagnosis, treatment, or referral maintained by federally assisted programs. These records are protected under 42 CFR Part 2, in addition to HIPAA.

These records may not be disclosed without written patient consent except as permitted by federal law. Unauthorized disclosure is prohibited and subject to penalties.

Current federal regulations effective through 2026 allow certain disclosures for treatment, payment, and healthcare operations with patient consent while maintaining enhanced confidentiality protections.

Additional Disclosure Authorization

In addition to allowable disclosures described in our Notice of Privacy Practices, you may authorize Union Bay Dental Care to disclose your protected health information to the individuals listed below. Please check YES or NO for each category.

Spouse only _____ YES ___ NO ___
Immediate family _____ YES ___ NO ___
Extended family _____ YES ___ NO ___
Other: _____ YES ___ NO ___

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and healthcare operations. You may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on it.

Patient Name (Print): _____
Patient Signature: _____ Date: _____
Practice Representative: _____ Date: _____