PATIENT INFORMATION

Today's Date:_____Email Address: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____**Prefix:** _____

I prefer to be called: _____ **D.O.B.:** _____/_____/_____ Age: _____

SSN: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □Separated

Home Address: _____

Street City State Zip

Home Phone:_____ **Cell Phone**: _____ **Work Phone:**_____

Where & when are the best time to reach you? _____**Driver License #**: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Street City State Zip

Emergency Contact (Name/Phone#) _____

How did you hear about us?

□ Print □ Insurance Website

□SearchEngine: _____ □Social Media- Instagram, Facebook,Yelp, etc.

□ Word of Mouth: _____ □ Other: _____

(referrer's name)

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: _____ Relation: _____ Home Phone:_____

Social Security #: _____ Employer: _____

Work Phone:_____ Driver License #: _____

Billing Address: _____

Street City State Zip

INSURANCE INFORMATION

Primary Insurance Dental Coverage? □Yes □No Orthodontic Coverage? □Yes □NoMedical Coverage? □Yes □No

Insurance Co. Name: _____ Phone: _____ Group#(Plan, Local or Policy#): _____

Insurance Co. Address: _____

Street City State Zip

Insured's Name: _____ Insured's SSN _____ Insured's D.O.B.: _____/_____/_____

Insured's Employer: _____ Employer's Address: _____

Street City State Zip

SecondaryInsurance Dental Coverage? □Yes □No Orthodontic Coverage? □Yes □NoMedical Coverage? □Yes □No

Insurance Co. Name: _____ Phone: _____ Group#(Plan, Local or Policy#): _____

Insurance Co. Address: _____

Street City State Zip

Insured's Name: _____ Insured's SSN _____ Insured's D.O.B.: _____/_____/_____

Insured's Employer: _____ Employer's Address: _____

Street City State Zip

WELCOME TO PRIME CARE DENTAL

Continued on BACK →

DENTAL HISTORY

1. Why have you come to the dentist today?

_____

2. Are you currently in pain? .....□Yes □No
3. Do you require antibiotics before dental treatment? .....□Yes □No
4. Former Dentist _____
5. When did you last visit a dentist? _____
6. Last dental X -ray: _____
7. Any untreated dental issue? If yes, please explain:_____
8. When was your last cleaning? _____
9. Are you concerned with bad breath (malodor)? ..... □Yes □No
10. Are you concerned with snoring or sleep apnea? ..... □Yes □No
11. Have you had braces? ..... □Yes □No
12. Are you concerned with grinding/clenching?.....□Yes □No
13. Do you wear a biteguard? ..... □Yes □No
14. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?).....□Yes □No
15. Do your gums ever bleed?.....□Yes □No
16. Have you ever been treated for gum disease? ..... □Yes □No
17. Do you have mobility in your teeth?..... □Yes □No
18. Are your teeth sensitive to:

□Nothing □Sweet □Cold □Heat □Pressure

MEDICAL HISTORY

1. Physician&Practice_____
2. When was your last physical examination?_____
3. Are you under the care of a physician?..... □Yes □No

If yes, for what reason(s)?

_____

4. Are you presently taking any medications?..... □Yes □No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant?..... □Yes □No

If yes, anticipated due date? _____

6. Do you take oral contraceptives? ..... □Yes □No
7. Any allergies? _____
8. Do you smoke, chew tobacco, or use E-cigarettes? ..... □Yes □No

If yes, please indicate which one(s), daily frequency, and how long?

_____

9. Do you have Diabetes? ..... □Yes □No

If yes, please indicate: □Type 1 □Type 2

Last HbA1c date and level: _____

10. Do you take pre-medication for anything? ..... □Yes □No

If you pre-medicate, what for? _____

11. Have you had any other serious illness, hospitalization or accident? ..... □Yes □No

If yes, please explain: _____

12. Do you have, or have you ever had:

Abnormal blood pressure..... □Yes □No
Anemia ..... □Yes □No
Arthritis ..... □Yes □No
Artificial heart valve/stent/graft..... □Yes □No
Artificial joint replacements ..... □Yes □No
Asthma ..... □Yes □No
Cancer ..... □Yes □No
Chemical dependency ..... □Yes □No
Chemotherapy/radiation ..... □Yes □No
Congenital heart defects ..... □Yes □No
Corticosteroid treatment ..... □Yes □No
Epilepsy/seizures ..... □Yes □No
Excessive or prolonged bleeding ..... □Yes □No
Fainting spells ..... □Yes □No
Glaucoma ..... □Yes □No
Hearing impaired ..... □Yes □No
Heart murmur ..... □Yes □No
Heart pacemaker ..... □Yes □No
Heart surgery ..... □Yes □No
Heart trouble ..... □Yes □No
Hepatitis (Type ___) ..... □Yes □No
HIV positive/AIDS ..... □Yes □No
Jaundice ..... □Yes □No
Kidney trouble/Dialysis ..... □Yes □No
Leukemia ..... □Yes □No
Oral herpetic lesions ..... □Yes □No
Osteoporosis/treatment/Bisphosphonates..□Yes □No
Psychiatric care ..... □Yes □No
Rheumatic fever ..... □Yes □No
Sexually transmitted disease ..... □Yes □No
Sinus trouble ..... □Yes □No
Stroke ..... □Yes □No
Thyroid problem ..... □Yes □No
Tuberculosis or Lung Disease ..... □Yes □No
Ulcers/GERD ..... □Yes □No

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____. **PAYMENT IS DUE AT TIME OF SERVICE**

Patient Signature _____ **Date** _____

(Parent/Guardian)

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Han-Tae Choi all insurance benefits, otherwise payable to me. I understand that I am responsible forpayment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient Signature _____ **Date** _____

(Parent/Guardian)

WELCOME TO PRIME CARE DENTAL

Prime Care Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ have been given a copy of Prime Care Dental(Han-Tae Choi, DDS) Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Prime Care Dental(Han-Tae Choi, DDS) has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Official, or by visiting Prime Care Dental(Han-Tae Choi, DDS) office.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

Print Name: _____

If Personal Representative: _____
(title - e.g., guardian, executor, power of attorney, etc.)

Internal use only: Complete this section if unable to obtain a signature.

An attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented signature
- ☐ Communication barriers prevented signature
- ☐ Other (please specify):

(THERE ARE TWO SIDES- PLEASE TURN OVER)

Prime Care Dental

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

I,_____, give Prime Care Dental and/orstaff authorization to disclose protected health information to the following family and/or caregivers.

NAME:_____ Relationship:_____

NAME:_____ Relationship:_____

NAME:_____ Relationship:_____

NAME:_____ Relationship:_____

I understand that I have the right to revoke this authorization at any time.I understand that if Irevoke this authorization, I must do so in writing and present my written revocation to the office of Prime Care Dental(Han-Tae Choi, DDS).

I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to information shared in the process of treatment or payment as cited in the Notice of Privacy Practices. Unless otherwise revoked this authorization will expire on the following date, event, or condition:

_____.

This notification is indefinite unless specified in writing.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.If I have questionsabout the disclosure of my health information,I can refer to my Notice of Privacy, which I obtainedfrom my dental office.

Signature of Patient:_____ Date: _____

Signature of Parent/Guardian
or Personal Representative:_____ Date:_____

(THERE ARE TWO SIDES- PLEASE TURN OVER)

Prime Care Dental

Han-Tae Choi, D.D.S.

3057 E. Warm Springs Rd., Suite 300, Las Vegas NV 89120

Telephone: (702) 369-8730

Agreement of Financial Responsibilty:

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to this office. The responsible party agrees to:

1. Payment in full at the time of service is required by cash, check, debit, or credit card.
2. That if payments are extended beyond 30 days from the date of the first billing a service charge of 1.5% per month (annual rate of 18%) will be assessed against the unpaid balance with a minimum charge of $1.00 per month.
3. If you have dental insurance – Prime Care Dental(Han-Tae Choi, DDS) and staff take no responsibility for accurate estimation of your insurance benefits. As a courtesy, we will file your claim for you. We will estimate your deductible and your portion, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from your insurance company's schedule of "allowable" or "UCR" fees. If you have questions about those fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage.
4. Any amounts left unpaid by your insurance after 45 days will become solely your responsibility.

   Please initial here: _____ to indicate your acceptance of this policy.
5. Personal credit may be checked.
6. I have received a copy of the Financial Policy of this office.
7. There will be a $50 fee charge for any returned check or any appointments not cancelled with at least a 24 hour notice.

   Please initial here: _____ to indicate your acceptance of this policy.

_____

Signature Date

PHOTO USE RELEASE FORM

I, _____, hereby grant and authorize Prime Care Dental the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures or video taken of me by Prime Care Dental to be used in and/or for legally promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social networking sites and other print and digital communications, without payment or any other consideration. This authorization extends to all languages, media, formats and markets now known or hereafter devised. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of Prime Care Dental and will not be returned.

I hereby hold harmless, and release Prime Care Dental from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

I warrant that I am of the age of consent (18 years or older) or that I am the parent or legal guardian of _____ [Child] and That I am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning and impact of this release.

Patient Signature and Date: _____

Print Patient Name: _____

Parent/Legal Guardian Name and Date: _____