D'ART DENTAL CLINIC
3420 ave K, #140, Plano, TX 75074
T.972.424.8023 info@D-Artdental.com

Today _____

Patient Information

Name	(Last)	**Birth Date (mm/dd/yy)**	/ /	
	(First)	**SSN**		Gender(M/F)
Address		**Home phone**		
	(City)	**Cell phone**		
	(State) (Zip)	**E-mail**		
Status	□ Minor □ Single □ Married, Name of Spouse (could we send our news & promotion Y/N)			
Employer	(Name) (Phone)			
	(Address)			

- Whom may we thank for referring you? □ newspaper □ internet □ others ( )
- Whom can we call in emergency? (Name/Relationship) (phone)

Dental Information

- Reason for this visit (main concern)
- Are you currently in pain? □ Yes □ No
- When was your last visit to dental clinic? • For what reason?
- When was your last cleaning? • Last full mouth X-ray?
- What methods have you been used in the past to assure your comfort while having dental care?

□ Local Anesthetics □ Nitrous Oxide □ I.V sedation □ Pre-OP sedation □ Headphones

Insurance Information

• Primary Insurance

Subscriber Name		Relationship to Patient	
Birth Date (mm/dd/yy)	/ /	SSN	
Name of Employer		phone	
Insurance Company		Plan	□ PPO □ DMO □ Other
Group #			

• Secondary Insurance

Subscriber Name		Relationship to Patient	
Birth Date (mm/dd/yy)	/ /	SSN	
Name of Employer		phone	
Insurance Company		Plan	□ PPO □ DMO □ Other
Group #			

Medical History

- Are you currently under medical care? ☐ Yes ☐ No
  If Yes, for what?

- Do you take any medications regularly? ☐ Yes ☐ No
  If Yes, what are they?

- Do you currently take any medication related to **Aspirin (Blood Thinner)**? ☐ Yes ☐ No

- Have you ever taken any medication related to **Osteoporosis**? ☐ Yes ☐ No
  If Yes, explain

- Have you ever been admitted to a hospital or needed emergency care? ☐ Yes ☐ No
  If Yes, for what?

- Have you ever had any of the following? Please check those that apply

☐ Abnormal Bleeding	☐ Anemia	☐ Sickle cell disease, traits	☐ Osteoporosis	☐ Rheumatic Scarlet Fever
☐ AIDS, HIV+	☐ Hepatitis B/C	☐ STD	☐ Tuberculosis	☐ Herpes, Fever Blisters
☐ High Blood Pressure	☐ Diabetes	☐ Stroke	☐ Heart Disease	☐ Heart Attack
☐ Arthritis	☐ Artificial Bones	☐ Artificial Joint	☐ Sinus Problems	☐ Low Blood Pressure
☐ Kidney Disease	☐ On Dialysis	☐ Liver Disease	☐ Stomach Problems	☐ Thyroid Problems
☐ Cancer	☐ Hemophilia	☐ Glaucoma	☐ Shingles	☐ Lupus
☐ Respiratory Disorder	☐ Emphysema	☐ Asthma	☐ Difficulty breathing	☐ Venereal Disease
☐ Nervous Disorder	☐ Seizure	☐ Psychiatric Disorder	☐ Smoking	☐ Alcohol/Drug Abuse

- Are you allergic to any of the following?

☐ Aspirin	☐ Codeine	☐ Dental Anesthetics	☐ Latex	☐ Jewelry
☐ Penicillin	☐ Erythromycin	☐ Tetracycline	☐ Hay fever/Allergy	☐ Other ( )

- For Women : Are you taking birth control pills? ☐ Yes ☐ No
  Are you pregnant? ☐ Yes ☐ No **If Yes**, Week #
  Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient / Guardian _____ Date _____

Privacy Notice

I authorize the dentist to release any information including any diagnosis and the records of any treatment or examination related to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient / Guardian _____ Date _____

Consent for Services

I acknowledge that the Practice will explain to me in specific terms the diagnosis of my condition, the basis for their Treatment plan recommendations, specific descriptions of the proposed Treatment plan, the alternatives(including non-treatment) and the risks and inconveniences. I will be given every opportunity to ask any questions and any such questions have been answered or explained to my satisfaction. By signing below, I acknowledge that I have been given time to read and have read the preceding information ir this document and I agree to assume the risks and inconveniences of my treatment. I also agree that any/all disputes will be held between Members of the Practice and me. Though occurring less than 1% of the time if there is a concern or expectation that was not realized I will do all in My power to let the treating doctor remedy the situation and/or concern. no third parties will be consulted and all issues will be dealt with directly with the practice I consent to the production of records, including X-rays, photographs, prescriptions, and other information which may include personal information before, during and after treatment(together, "Records"). The practice may disclose my records for treatment, payment, or healthcare operations, including disclosure to laboratories, other dental offices or professionals involved in my care, and to my insurance providers. I further agree that the photos taken are the property of Dr.Suh. The practice and they may be used for educational purposes, website use, lecturing, advertising, marketing and/or any and all office uses. These photos will be used with discretion, and may involve any part of the treatment phases. I understand this form and I consent to the Treatment Plan.

As a condition of treatment by this office, financial arrangements must be made in advance. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I authorize the dentist to release any information including diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of one month from the date of the patient examination.

In consideration for the services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment or within five das of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me I writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

OFFICE POLICIES

We would like to welcome you to our office, and are happy you have chosen our office for your dental care.

Our goal is to provide you with the best care available. We believe it is important that our patients fully understand our financial and office polices, so we may concentrate on you and your dental needs. It is your responsibility to notify us of any changes in your account status(i.e. change in address, work/home/cell numbers and/or insurance) Pleas let us know if we can answer any questions.

INSURANCE COMPANIES

We are here to help answer any questions you may have regarding your dental insurance coverage and payments. However, your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy to you, our patient, we file your insurance for you. Even though we file your insuranc for you, you are still financially responsible for the balance on your account. Your insurance company will pay what they feel is the going rate in our area, that my or may not b what our fees are, or they will pay according to the fee schedule that you are assigned to. The patient is responsible for any unpaid balance by your insurance company. If you have secondary insurance, we will be happy to provide you with the necessary information for you to file.

FINANCIAL RESPONSIBILITY

Full payment of services is due at the time services are rendered. If you have dental insurance, your estimated portion plus any deductibles will be due the day services are rendered. In the event that your insurance company does not cover your treatment or does not pay what is estimated from them, then you are responsible for any remaining balance in full. We accept cash, Visa, MasterCard, Discover and American Express card. We also offer Care Credit and Citi Health Card for financing options. If you have any concerns with this policy, please let one of our staff members know.

MISSED APPOINTMENTS

We serve time exclusively for you. We do not double-book our patients and thus insure the proper length of appointment time to render the ultimate care for our patients. Appointments missed or not cancelled within 48 WEEKDAY(Mon-Fri) hours are subject to a minimum $50.00 charge.

Thank you for choosing our office for your dental needs. We believe it is important that our patients fully understand our financial and office polices, so we may concentrate o you and your dental needs. It is your responsibility to notify us of any changes in your account status(i.e. change in address, work/home/cell numbers and/or insurance) Please let us know if we can answer any questions.

I hereby certify that I have read and understand the previous information and I understand and agree to these policies.

I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible fo any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsibl for payment of all services rendered on my behalf or on behalf of my dependents(if any).

Signature of Patient / Guardian

Date