Dr. Si-Hyeon Lee
381 Gateway Drive, Suite 9
Winchester, VA 22603
(540) 773-3206
www.ShineDentalWinchester.com

Date: _____

Name: _____
Last *First* *MI*

Mailing Address: _____
Street *City* *State* *Zip*

Male ◯ Female ◯ Age: _____ Birthdate: _____ SSN: _____

Preferred Name: _____ ProNoun: _____
Single ◯ Married ◯ Divorced ◯ Widowed ◯ Minor ◯

Cell Phone: _____ Text OK? Yes No Home Phone: _____

Email: _____

Employer/School: _____ Work Number:_____

How did you hear about our office? _____

Parent/Guardian Information (For Patients 18 and Younger)

Parent/Guardian Name: _____
Last *First* *MI*

Address (if different from patient's)_____

Male ◯ Female ◯ Age:_____ Birthdate:_____ SSN: _____

Cell Phone: _____ Text OK? Yes No Home Phone:_____ Email:_____

Employer: _____ Work Phone:_____

Insurance Information

Subscriber Name _____Relationship to Patient _____ Subscriber DOB _____

Insurance Co. Name _____ Subscriber ID _____

Group Name _____Group # _____ Ins. Co. Phone _____

I certify that I have read and understand the following questions, and questions above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my doctor, or his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Signature of Patient (or Parent/Guardian) *Date* *Reviewed By*

Medical History

Primary Care Physician: _____ Phone: _____

Are you currently under the care of a physician: __no __ yes *Reason (if yes):* _____

Have you had any operations in your lifetime? ___no ___ yes *Reason (if yes):*_____

Do you use tobacco in any form? ___no ___yes

Have you had any rods, implants, or pins placed? ___no ___yes

Are you required to pre medicate prior to dental treatment? ____no ____ yes

Check ***yes*** if you have or have had any of the following:

___ Abnormal Breathing
___ Alcohol/Drug Abuse
___ Anemia
___ Angina Pectoris
___ Anxiety
___ Arthritis
___ Artificial Heart Valve
___ Asthma
___ Bipolar
___ Blood Transfusion
___ Cancer
___ Chemotherapy
___ Congenital Heart Defect
___ Depression
___ Diabetes
___ Epilepsy
___ Fainting
___ Fever Blisters
___ Glaucoma
___ HIV/AIDS
___ Heart Attack
___ Heart Murmur
___ Hepatitis (A, B, or C)
___ High Blood Pressure
___ High Cholesterol
___ Joint Replacement
___ Kidney Issues
___ Liver Disease
___ Low Blood Pressure
___ Mitral Valve Prolapse
___ Pace Maker
___ Radiation Therapy
___ Rheumatic Fever
___ Seizures
___ Sexually Transmitted Disease
___ Shingles
___ Sinus Issues
___ Stroke
___ Thyroid Problems
___ Tuberculosis
___ Ulcers

(Women) Are you pregnant? ___ yes ___ no Nursing? ___yes ___ no Taking Birth Control? ___yes ___no

Name of OB/GYN Physician: _____ Phone: _____

Medications

Please list all medicine, drugs, pills, over-the-counter medications you are taking:

_____

_____

Allergies

Have you had an allergic or adverse reaction to anesthetic? ___yes ___ no (if yes explain) _____

Please List **ANY** medications you are allergic to:

_____**Latex Allergy** ___yes ___no

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____ _____

Signature of patient (Parent or Guardian if minor) *Date* *Reviewed by*

Dental History

What is your reason for visiting Shine Dental today? _____

When was your last dental cleaning and visit? _____

Why did you leave your previous dentist? _____

How may we accommodate you better during your dental visit? _____

Are you happy with your smile? If not, what would you like to change? _____

Would you describe your current dental condition as: _____ Good _____Fair _____ Poor

How often do you brush and floss your teeth? _____

Check yes if any of the following apply to you: (Please explain further in space provided)

___ Are you currently experiencing dental pain? _____

___ Have you had past gum treatment? _____

___ Have you had any difficulty with past dental experiences? _____

___ Do you now have, or have you had any pain/discomfort in your jaw (TMJ)? _____

___ Have you lost any teeth? _____

___ Do your gums bleed when brushing or flossing your teeth? _____

___ Are your teeth sensitive to hot, cold, or biting? (Please circle any that apply)_____

Here at Shine Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle below any service you would like our friendly staff to discuss with you during your visit today:

Tooth Whitening	Veneers/Lumineers	Invisalign/ Braces
Sports or Night Guard	Tooth Bonding	Partial/ Dentures
Sealants	Crown or Bridges	Dental Implants

FINANCIAL & APPOINTMENT CONSENT FORM

Welcome to our practice!

We look forward to providing you with exceptional dental care. To provide you with the most beneficial and comprehensive service, we do ask that you review and complete our appointment and financial policy form.

Dental Insurance

As a complimentary service, we will file claims with your primary dental insurance company. In order for us to timely file the claim and collect payment, we ask that the correct insurance information be provided prior to your appointment. If this information changes, it is your responsibility to update our office immediately. We will accept payment from your dental insurance company, however, we are only contracted with certain insurance companies. Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as a dental care provider, our relationship is with you, NOT your insurance company. Your insurance is a contract between you, your employer and the insurance company. Our office will provide you with an ESTIMATE of your out-of-pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. While the filing of primary insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 45 days from the date of service become the immediate responsibility of the patient and/or account holder.

Payment, Co-pays & Deductibles

Payment for co-pays and/or deductibles is due at the time services are provided. Payment may be paid by cash, check, Visa, Mastercard, Discover or American Express. Our office also accepts payment through CareCredit. CareCredit is bank financing for qualified applicants who prefer additional time to pay their balance. It is a revolving line of credit through an independent financial institution. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care and treatment not covered by insurance. CareCredit has financing options available that include 6, 12 and 18 months interest free, as well as extended payment plans with a minimal APR. We will gladly discuss your proposed treatment, financial options and any other questions you may have.

Account Balances & Charges

If a balance remains on the account after 90 days, the account will be sent to a collection agency and additional collection fees will be applied to any unpaid balance. Any attorney or collections fees incurred due to delinquency in payment will also be charged to the patient. Any personal check returned unpaid or with non-sufficient funds (NSF) will incur charges to recover the face amount of the check, along with a $30 NSF check fee to absorb bank charges to our office. If financial problems occur, we ask that you contact us promptly for assistance in the management of your account.

Cancellations & Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 24 hour cancellation notice. Your scheduled time has been saved only for you and the doctor or hygienist. Due to staff overhead that occurs in broken appointment slots, a cancellation fee of $50 is charged if a 24 hour notice is not given. We appreciate your efforts to keep scheduled appointments.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED BY SHINE DENTAL KIDS AND FAMILY DENTISTRY.

_____ _____

Printed patient name Relationship to patient

_____ _____

Signature of patient/parent/legal guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Relationship to the Patient

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.
If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ I decline to receive communications via **text**.

_____ I decline to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____