MEDICAL HISTORY / FINANCIAL INFORMATION FORM

Patient Information: *Nickname:*_____ *Employer:*_____ *Occupation:*_____
First Name _____ *Middle* _____ *Last Name* _____
Address _____ *City* _____ *State* _____ *Zip Code* _____
Telephone: *Home* (_____) _____ - _____ *Work* (_____) _____ - _____ *Cell* (_____) _____ - _____
S.S. # _____ - _____ - _____ *Date of Birth:* _____ *Age:* _____ *SEX:* ❑*Male* ❑*Female*
Marital Status: ❑Single ❑Married ❑Widow **Email:**_____

Account Information:→ ***For the responsible party of a patient that is under age 18 or an incompetent patient age 18 or older.***
Print Full Name _____ *Date of Birth:* _____ SEX: ❑Male ❑Female
Address _____ *City* _____ *State* _____ *Zip Code* _____
Telephone: *Home* (_____) _____ - _____ *Work* (_____) _____ - _____ *Cell* (_____) _____ - _____
S.S. # _____ - _____ - _____ *Employer:*_____ *Occupation:*_____
Marital Status: ❑*Single* ❑*Married* ❑*Widow* Relation to Patient: ❑*Self* ❑*Spouse* ❑*Parent* ❑*Guardian* ❑*Facility*

Dental Insurance Company *(Primary):* _____ (No DMO plans= plan where you pick a primary dentist)
Name of Subscriber: _____ *Date of Birth:* _____ *Subscriber ID#:* _____
Dental Insurance Company *(Secondary):* _____ *(Secondary: for a patient with a second dental plan)*
Name of Subscriber: _____ *Date of Birth:* _____ *Subscriber ID#:* _____

DENTAL HISTORY: Purpose of Today's Visit: _____ Referred By: _____
(Estimates Only) Last Dental Visit: _____ How often do you Brush your Teeth: _____
Last Cleaning: _____ Last Bite-Wing (CHECK-UP) X-rays:_____ Last full set of x-rays (FMX) or Panoramic Film:_____

PRIMARY CARE PHYSICIAN (Medical Doctor): _____ Telephone: (_____) _____ - _____
Last visit: _____ Name and Date of Last Prescription for **Pain**: _____
Pre-Medication and instructions:_____
MEDICATIONS: (current list)

FEMALE History: ❑**Pregnant** (____ Months) ❑Trying to get Pregnant ❑Nursing ❑Taking Oral Contraception's ❑Reached Menopause

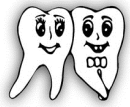
ALLERGENS: ❑None ❑Latex Rubber ❑Lidocaine ❑Acrylic ❑Metal ❑Sulfa Drugs ❑Penicillin ❑Aspirin ❑Motrin ❑Tylenol ❑Amoxicillin ❑Vinyl ❑Mepivacaine ❑Epinephrine ❑Percocet ❑Vicodin ❑Ibuprophine ❑Acetaminophen
Other:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Smoke or Chew Tobacco	❑	❑	Stroke	❑	❑	Artificial Joint	❑	❑	Sickle Cell Disease	❑	❑	Nervous of Dentist
❑	❑	History of Drug Abuse	❑	❑	HIV / AIDS	❑	❑	Wheelchair Patient	❑	❑	Thyroid Disease	❑	❑	Nervous Disorder
❑	❑	_____cancer	❑	❑	Venereal Disease	❑	❑	Hearing Problems	❑	❑	Parkinson's Disease	❑	❑	Diabetes
❑	❑	Angina / Chest Pain	❑	❑	Genital Herpes	❑	❑	Deaf / Hearing Impaired	❑	❑	Head Injury	❑	❑	Bruise Easily
❑	❑	Heart Attack / Failure	❑	❑	Hepatic Infection	❑	❑	Blind / Sight Impaired	❑	❑	Hives or Rash	❑	❑	Arthritis
❑	❑	Heart Disease	❑	❑	Hepatitis B	❑	❑	Earache	❑	❑	Skin Sores / Blisters	❑	❑	TMJ / Jaw Pain
❑	❑	Heart Murmur	❑	❑	Hepatitis C	❑	❑	Headaches	❑	❑	Tumors or Growths	❑	❑	Epilepsy (seizures)
❑	❑	Heart Surgery	❑	❑	High Blood Pressure	❑	❑	Shortness of Breath	❑	❑	Cortisone Medicine	❑	❑	Risky Behavior
❑	❑	Heart Valve Problems	❑	❑	Low Blood Pressure	❑	❑	Respiratory Disease	❑	❑	Thoughts of Suicide	❑	❑	Jaundice
❑	❑	Pulmonary Embolism	❑	❑	Parathyroid Disease	❑	❑	Lung Disease	❑	❑	Rheumatism	❑	❑	Colitis
❑	❑	Bleeding Problems	❑	❑	Portal Hypertension	❑	❑	Emphysema	❑	❑	Swelling of Limbs	❑	❑	Paranoia
❑	❑	Excessive Bleeding	❑	❑	Rectal Bleeding	❑	❑	Breathing Problems	❑	❑	Crohn's Disease	❑	❑	Gout
❑	❑	Bruxism (teeth Grinding)	❑	❑	Fainting / Dizziness	❑	❑	Asthma	❑	❑	Anemia	❑	❑	Depression
❑	❑	Positive Chest X-ray	❑	❑	Digestive Tract Ulcer	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Mood Swings
❑	❑	Oxygen Tank for Breathing	❑	❑	Hallucinations	❑	❑	Rheumatic Fever	❑	❑	Cataracts	❑	❑	Liver Disease
❑	❑	Recent Blood Transfusion	❑	❑	Leukemia	❑	❑	Alzheimer's Disease	❑	❑	Patient on Dialysis	❑	❑	Psychiatric Care
❑	❑	Stomach or Peptic Ulcer	❑	❑	Cerebral Palsy	❑	❑	Convulsions	❑	❑	Stomach Disease	❑	❑	Violent Behavior
❑	❑	Painful Urination	❑	❑	Blood in Urine	❑	❑	Blood in Stool	❑	❑	Constipation	❑	❑	Heartburn

***Additional Health Information?**_____

By signing below, I agree that I am the legally responsible party of the patient, I have read and understand the privacy practices related to this office (HIPPA Act), information on this form is current and correct to the best of my knowledge, and I will update this information with this office before treatment is performed. Upon request, a new Medical History form will be filled out every 2-3 years.

_____ _____ _____
Signature of Responsible Party **Print Full Name of Responsible Party** **Date**



Medical History Reviewed by Dr: _____ Dr. Signature: _____ Date: _____

Medical Updates:

Date	Exceptions	None	Patient's initial	BP	Reviewed by
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

D/B/A SMILAGE DENTAL CENTER

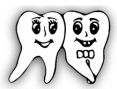
FINANCIAL AGREEMENT FORM

SHAM, TANG, AND TAM, P.C.

This financial agreement is in place to explain our office policies and to inform you of your financial obligation to our dental practice. As a dental professional we will always recommend treatment based upon your dental needs and not based on insurance coverage. Our goal is to provide the finest care and treatment to all our patients at a reasonable cost in a safe, clean, comfortable, and friendly environment. Please remember to sign, print name, and date at the bottom of the page.

- **Check-in:** Any patient under age 18 or incompetent patient 18 or older must be accompanied by an adult. Please arrive 15 minutes early (30 minutes early for any new patient). Food or drink products are NOT permitted in the office. *Our office reserves the right not to see any uncooperative patient or for any unacceptable behavior (no shoes, no shirt, p*rofanity, yelling, running, stealing, throwing items, etc.). Please be aware that unforeseen dental emergencies or unexpected complications may occur in some cases which results in little to no notice in avoiding a conflict with other patient appointments. Please be aware that a valid picture identification of the responsible party and proof of any insurance will be required to prevent fraudulent activity. Proof of any guardianship/facility will be required. Please remember to turn off your cell phone in the treatment room. Thank you for your cooperation.
- **Appointment Reminders:** As a courtesy to all our patients an electronic appointment reminder will be provided. An electronic appointment reminder is an online service that is easy to use and a very convenient method to provide you with a 6 month recall reminder, appointment reminders, and confirming your appointment all by email and/or text. Please be aware that any email or cell number you provide may be added to our online appointment system to receive electronic appointment and 6 month recall reminders. A courtesy appointment reminder call may NOT be provided for any office with electronic reminders. Please remember to provide or update any valid contact information when you check-in would be greatly appreciated.
- **Broken Appointments:** It is your responsibility to remember and arrive at your appointment on time. Please create a reminder and remember to check your schedule to avoid broken appointments. **A $25.00 charge per half hour will be billed directly to you for any broken appointment unless a 24 hour notice is provided.** Broken appointments disrupt the scheduling of other patient visits, diminish the efficiency of office operations, increase operating costs, decrease revenue, and waste valuable human resources. If you break multiple appointments our office reserves the right to schedule any future appointments on an emergency basis with no specific dentist or to discharge you and/or all patients under the account from this practice.
- **Patient Payments:** Your patient payment portion is expected upon completion of each service. A deposit will be required at each visit for any multi-visit service. Taking care of your financial responsibility at the time of service is greatly appreciated. We accept MasterCard, Visa, Discover, Money Order, CareCredit, cash, and check to better serve you.
- **Patient Plans:** We are a CareCredit provider. A **CareCredit** medical credit card gives you and your family a payment option for healthcare expenses such as LASIK, Cosmetic, Dental, Veterinary, and Hearing. Please feel free to ask a receptionist for basic questions. You can apply online at www.carecredit.com or feel free to call (800) 365-8295.
- **Patient Copayments and Deductibles:** Most dental plans will only pay a percentage of the contracted fee for a covered service and you are responsible for your percentage portion which is called a patient copayment. This means that the insurance and the customer both pay some of the charges for dental work covered by your dental plan. A deductible is the amount of expenses that is paid by the insured or patient before the insurance will pay for any covered expenses. In about 30 days you and the dentist in most cases will receive the "explanation of benefits" (EOB) from the insurance usually indicating the services that are covered, any insurance payment to the provider, how much was paid by your dental plan, maximum used in some cases, and how much is your responsibility. Any estimated patient co-payment and any eligible deductible is your financial responsibility (please see "patient payments" for further details).
- **Insurance:** Confirmation of coverage and eligibility may be required for coverage. Insurance information and Subscriber information (subscriber ID, name, and date of birth) is normally required to confirm eligibility, submit a claim for payment, and to obtain a basic breakdown of coverage and benefits of your dental plan. **Dental plans are designed to share the cost of dental care. Although we may attempt to provide an accurate estimate of your insurance benefits, we are NOT responsible for their accuracy.** Dental staff cannot always answer specific questions about your coverage and benefits for a particular procedure because plans written by the same benefits company or offered by the same employer may vary according to the contracts involved. Your plan sponsor (often your employer) or the insurance company is usually in the best position to explain the individual design features of your dental plan. Please be aware that a patient with two or more dental plans does not guarantee a patient will have no patient payment. **Our relationship is with you and not your insurance company.** *Our practice will accept an assignment of benefits from your insurance company but it is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. It is the patient's responsibility to notify this office of any new dental plan, termination, or any changes to your dental plan on file with our office.* **By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation.** *Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction.* Completing insurance forms is a courtesy we extend in an effort to save you time and facilitate payment to our practice from your insurance company. Insurance payments are normally received within 30-60 business days from the time of billing. Insurance coverage is not a guarantee of payment. If your insurance company has not made payment to our practice within 60 days, we may ask you to pay the entire balance at that time and you will be responsible for seeking reimbursement from your insurance company. Our office reserves the right not to deal with, submit claims, or process claims to any medical insurance, additional dental insurance, or if our office is not a provider of your dental insurance plan. *It is your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice. It is your responsibility to understand all aspects of your dental policy and be aware of any changes to the coverage and benefits of your dental plan regardless of any conflict or dispute between other contracts or agreements. Receiving our services indicates your acceptance of responsibility that all charges you incur are your responsibility regardless of your insurance coverage.* Please see "patient copayments and deductibles" regarding further patient payment details.
- **Discounts:** Certain restrictions may apply and change without notice. Any coupon or discount is not valid with any other offers, promotions, coupons, adjustments, or discounts. Not valid for prior purchases or on sale merchandise or services. Any coupon or discount may not be valid if the service is not paid in full upon completion or the patient never returned to complete the service.
- **Prescriptions:** In most cases, you will need to be seen in regards to a request or refill for a prescription and/or a less or non-addictive prescription will be provided. *Our office reserves the right not to see any patient seeking only medication and not treatment and the right to deny a patient request or refill for a prescription.* In most cases, we will not provide or refill a prescription if you are referred out or seen another practice, specialist, or physician. A letter from your physician may be required to confirm any allergic reaction or pre-medication. *This office policy will help prevent addiction or overmedication to the patient and to help provide the appropriate diagnosis and treatment.* Your cooperation is greatly appreciated regarding our prescription policy.
- **Incomplete Services:** It is your responsibility to provide any expected payments and to schedule and arrive for your appointments. Our office deserves to be paid for any service that is completed but not delivered or for any office expenses and work performed for any incomplete service. Any multi-visit service not finished within a 60 day period or within the time limit recommended, the case may be closed and a claim may be submitted for the incomplete service to the insurance for the covered service but the patient is responsible for any remaining balance or determined by the work performed and any related expenses. An additional charge may apply if we retreat or redo any service related to the incomplete multi-visit service or incomplete treatment plan.
- **Collections and Unpaid Balances:** A late fee charge of $25.00 will be billed directly to you for any new or old patient balance 30 days past due or older. It is your responsibility to provide or update any valid contact information while your account has a balance. Please be aware that our office reserves the right not to see any patient with an account that has a past due balance or with any account on hold or under collection status. *Any account balance that is 90 days overdue and/or mail is returned in regards to a billing statement may be referred to a collection agency.* You understand that if your account is forwarded to a collection agency, in addition to the principal obligation, you will also be responsible for a collection fee equal to 30% of the principal obligation including a 10% additional charge when an account is elevated to legal status. (Example: if your principal obligation is $100.00, your balance will be $130.00 if your account is forwarded to a collection agency for a 30% collection charge). You are responsible for any and all office, collection agency, attorney, legal fees, and court expenses related to the collection of any balance you have with this office or with the collection agency and you understand that you will be discharged from this practice if your account is under collection status with our office until the account balance is paid in full and it is your responsibility to immediately find an alternative dental provider. You agree to contact the collection agency for the correct balance or payment related concerns.
- **Miscellaneous:** *We will not guarantee or be liable for any work performed in relation to fix or repair any work performed by another office or due to patient negligence.* You may be required to fill out a release form for copies of your records (a fee may occur for this service). A copy of records may only be provided to the responsible party or other individual with signed permission from the responsible party (photo ID may be required) in order to protect private information. Any treatment plan may be subject to change without notice or depending on condition and outcome of treatment. Most work is guaranteed for 1 year. This financial agreement including all office policies, obligations, charges, and procedures may be subject to change without notice.

Any reference to the patient for payment or responsibility aspects in this document are in regards to the responsible party of the patient. Any alteration of this document without management approval does not change the original document and such act is not acceptable and may result in patient discharge. By signing below, you agree that receiving our services indicates your acceptance of responsibility that all charges you incur are your responsibility regardless of your insurance coverage and you also agree that i*t is your responsibility to understand all aspects of your dental policy and be aware of current or any changes to the coverage and benefits of your dental plan regardless of any conflict or dispute between other contracts or agreements*. By signing below, I agree that I am the legally responsible party (competent patient 18 or older / parent / guardian / facility) of the patient and that I have read, understand, and agree to the terms and conditions stated above and I also agree to abide by all its guidelines in order for the patient to receive any services from this dental practice.



_____	_____	_____
Signature of Responsible Party	**Print Full Name of Responsible Party**	**Date**