

Patient Information

Patient Name _____
Last First Middle
() Male () Female () Married () Single () Child () Other
Social Security No. _____ Date of Birth _____
Phone (Home) _____ (Work) _____ (Cell) _____

Address _____

Name of Employer _____ Occupation _____

Address _____

=====

Medical History

Reason for visit _____

Date of Last Dental Visit _____

Have you ever taken any **blood thinner** or bone density medication? (Fosmax Plavix Cumidin Aspirin)Y/N

*Are you allergic to: Aspirin Penicillin Codeine Latex Local Anesthetic Other _____

*Have you ever had any complications following dental treatment? () Yes () No

If yes, please explain _____

*Have you been admitted to a hospital or needed emergency care during the past two years? () Yes () No

If yes, please explain _____

*Are you now under the care of a physician? () Yes () No

If yes, please explain _____

Name of Physician _____ Phone _____

*Do you have any **heart problems**? () Yes () No

*Have you ever been told you need **pre medication**? () Yes () No

*Are you **Pregnant** at this time? () Yes () No If yes, what is the due date? _____

*Have you ever had any of the following? Please, check those that apply:

- | | | | |
|------------------------------|------------------------------------|----------------------------|-------------------------|
| () AIDS | () Excessive Bleeding | () Liver Disease | () Tuberculosis |
| () Allergies _____ | () Fainting | () Mental Disorders | () Tumors |
| _____ | () Glaucoma | () Nervous Disorders | () Ulcers |
| () Anemia | () Growths | () Pacemaker | () Venereal Disease |
| () Artificial Joints | () Head Injuries | () Rheumatic Fever | () None |
| () Asthma | () Heart Murmur | () Radiation Treatment | () OTHER: _____ |
| () Blood Disease | () Hay Fever | () Respiratory Problems | |
| () Cancer | () High/Low Blood Pressure | () Rheumatism | |
| () Diabetes | () Hepatitis | () Sinus Problems | |
| () Dizziness | () Jaundice | () Stomach problems | |
| () Epilepsy | () Kidney disease | () Stroke | |

List the medications _____

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, Parent or Guardian _____
Date

Dr. Jeon's Implant Dentistry
2421 E. Tudor Rd. Suite # 101
Anchorage, AK 99507
Tel (907) 677-1212/ Fax (907) 677-1247

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Financial Policy of Dr. Jeon's Implant Dentistry

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy

Payment Options

Payment is due at the time of service, including any deductibles or co-payments. We accept the following forms of payment:

1. **Cash- Include personal check**
2. **Credit Card- MasterCard, or Visa**
3. **Care Credit-** offers a separate line of credit to cover your entire family's health care needs.
(Please ask the office staff for more information)

Insurance Billing

Insurance billing is a courtesy to our patients. If you have dental insurance coverage, we will provide you with assistance in filing to your insurance company. Insurance is not a form of payment.

We will accept payment from insurance companies with the following stipulations:

- You are expected to pay any estimated co-payment, which is your portion of the charges not covered by the insurance company, and any non-covered services at the time of your visit. You will also be required to cover any deductible. **These charges are due at the time of service.**
- We expect payment in full **within 60 days** for services billed to insurance. You will be completely responsible for your account if there are any problems or delays with the insurance company. If we receive a payment from your insurance company after your balance has been paid, we will issue you a refund. It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected, or if it has not been paid within 60 days. It is also your responsibility to understand your dental insurance benefits. You can call your insurance company or refer to your plan booklet for this information. We are not responsible for knowing what your insurance pays for services we are providing for you. If we have made an error we will gladly resubmit a corrected claim.

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Overdue Accounts

Accounts with balanced over 60 days will be turned over to Cornerstone Collection Agency. We have a payment plan option through Care Credit if you wish to make use of this. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be referred to a dentist of your choice. Returned checks may be subjected to charge additional \$30.00 collection fees.

No Shows & Cancellations of Scheduled Appointments

We incur the cost of dedicated providers and staff to provide scheduled appointments. We reserve the right to charge a fee for "no show" appointments and **appointments cancelled with less than 24 Business hours notice**. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "No Show." An appointment that is cancelled with less than 24 hours notice is recorded in the patient's chart as a "SNC" or short notice cancellation. We understand that there are legitimate reasons for a missed appointment, however, if **three (3) such events** occur in your chart we may ask you to find a new provider.

Short Notice Cancelled Appointments 1st time: \$50.00

2nd time: \$ 75.00

3rd time: Discharge from office

No Show

1st time: Warning and \$ 50.00

2nd time: Discharge from office

I have read and understand the above financial policy's of Dr. Jeon's Implant Dentistry. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party

Date

Printed Name

**Dr. Jeon's Implant Dentistry
2421 E Tudor Road Suite#101
Anchorage, AK 99507**

Authorization and Consent

To Photograph and Publish

The undersigned hereby authorizes Dr. Joshua Jeon

To photograph or permit other persons to photograph

(Name) _____

The undersigned agrees that Dr. Jeon may use and permit other persons to use to negatives, prints or duplicates prepared from such photographs for such purposes and in such a manner as either may deem appropriate.

The undersigned agrees the photographs may be used for purpose, including, but not limited to, dissemination to hospital staff, physicians, health professionals, students, and members of the public for educational, treatment, research, scientific, public relations, and charitable purpose and that such dissemination may be accomplished in any manner and that such use is subject only to the following limitations:

The undersigned has entered into this agreement in order to assist scientific, treatment, educational, public relations, and charitable goals and hereby waives any right to compensation for such uses by reason of the foregoing authorizations, and the undersigned and his/her successors or assigns hereby hold Dr. Jeon and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

The term "photograph" as used in the foregoing agreement, shall mean motion picture or still photography in any format or any medium including video tape or disc, digital recording or any other means of recording and reproducing images.

The consent to photograph and publish shall remain valid unless the undersigned or his/her legal representative withdraws, in writing, his/her authorization for future use.

Signature: _____ **Date:** _____

Print Name: _____

If signed for a minor, indicate relationship:

Witness: _____ **Time:** _____

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DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below

and read and sign & initials the section at the bottom of this form. **Patient Name:** _____

_____ 1. **WORK TO BE DONE**

I understand that I am having the following work done:

Fillings _____ Bridges _____ Crowns _____ Extractions _____ Impacted tooth removed _____ General Anesthesia _____

Root Canals _____ Other _____ **Initials** _____

_____ 2. **DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Initials** _____

_____ 3. **CHANGES IN TREATMENT PLAN**

I understand that during treatment It may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials _____

_____ 4. **CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (Including shape, fit, size, and color) will be before cementation.

Initials _____

_____ 5. **PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse on my periodontal condition. **Initials** _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that some risks and complications can occur from the treatment as follows:

- Root canal procedure requires anesthesia and multiple radiographs (X-rays)
- Local anesthesia injections sometimes causes trismus (difficulty in jaw opening), or paresthesia (temporary or permanent loss of sensation).
- Post-operative discomfort or swelling, lasting a few hours to several days, for which medications may be prescribed if deemed necessary by the doctor.
- Separation of root canal instruments during treatment which may, in the judgment of the Dentist/Doctor, be left in the treated root canal or requires surgical procedure for removal.
- Perforation of the root canal due to curved roots or existing conditions. This may require additional surgical treatment or extraction.
- Access through a crown or bridge (existing restorations may result in damage to restoration, which is not the responsibility of your dentist).
- Allergic reactions to medications or anesthetics.

Signature of Patient or Legal guardian _____ Date _____

Signature of Witness _____ Signature of Doctor _____

7. REMOVAL OF TEETH (EXTRACTION)

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr. _____ to remove the following teeth _____ and any others necessary for reason in paragraph #3. I understand the risks involved in having teeth removed, some of which are pain, bleeding, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia), that can last for an indefinite period of time (days or months) or fractured jaw, damage to adjacent structures, anesthetic (medication) complications and pregnancy (**only female** patient-the use of any narcotic and/or sedative drugs during pregnancy can be very harmful to your unborn baby. If you are a female of childbearing age and health, you must be certain that you are not pregnant at the time of your surgery. If you are not sure, this procedure should be postponed until you have had a through professional exam consenting of a non pregnancy. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. I understand that reasons for this recommendation, potential benefits from this procedure, and the alternative treatment options. I have had my questions answered. I accept these risks and give my consent for surgery.

Signature of Patient or Legal guardian _____ Date _____

Signature of Witness _____ Signature of Doctor _____

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____