Ky Ken Yebisu, DDS

Acct # _____

Personal Information

Last Name	First Name	Marital Status □ Single □ Married □ Widowed □ Divorced	Who may we thank for referring you to our office?
Social Security Number	Date of Birth	Home Phone ( )	Work Phone ( )
Email Address			Cell Phone ( )
Residence Address	City		Zip Code
Driver's License Number	Employer		Occupation
Work Address	City		Zip Code
Person to contact in case of an emergency	Relationship		Phone Number ( )

Financial Information

Person Responsible for Payment	Relationship	Method of Payment □ Cash □ MC □ Check □ VISA	Bank & Account # (if paying by check or credit Card)
Social Security Number	Date of Birth	Home Phone ( )	Work Phone ( )
Email Address			Cell Phone ( )
Residence Address	City		Zip Code
Driver's License Number	Employer		Occupation
Work Address	City		Zip Code

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. In the event payments are not received upon the agreed-upon dates, I understand that a finance charge will be added to my account.

Date: Signed:

Insurance Information

Employee's Name (Primary Carrier)	Birthdate	Social Security Number	Employer's Name
Employer's Address	City	State	Zip Code
Group Name	Group (Policy) Number	Local	Relation to Patient □ Self □ Child □ Spouse □ Other	Name of Insurance Company

Employee's Name (Secondary Carrier)	Birthdate	Social Security Number	Employer's Name
Employer's Address	City	State	Zip Code
Group Name	Group (Policy) Number	Local	Relation to Patient □ Self □ Child □ Spouse □ Other	Name of Insurance Company

Ky Ken Yebisu, DDS

Medical History

How would you describe your general Health? □ Excellent □ Good □ Fair □ Poor

□ Yes □ No Have you been under the care of a physician in the last two years?

Please Explain: _____

□ Yes □ No Have you been hospitalized in the last two years?

Please Explain: _____

□ Yes □ No Have you taken any drugs or medications in the last year?

Please list: _____

_____

_____

□ Yes □ No Are you allergic or sensitive to any drugs or medications?

□ Penicillin □ Codeine □ Other _____

Physician's Name		
Physician's Phone Number		
( )		
Physician's Address		
City		
State	Zip Code	Date of last visit

□ Yes □ No Women - Are you pregnant?

How far along? _____

□ Yes □ No Do you smoke?

How much? _____ /day

Do you have (or have you ever had) any of the following?

□ Yes	□ No	Heart Surgery	□ Yes	□ No	Blood Pressure Problems	□ Yes	□ No	Diabetes	□ Yes	□ No	AIDS
□ Yes	□ No	Heart Murmur			□ High □ Low	□ Yes	□ No	Hepatitis	□ Yes	□ No	Jaundice
□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	Trouble with Breathing	□ Yes	□ No	Epilepsy	□ Yes	□ No	Arthritis
□ Yes	□ No	Head Injuries	□ Yes	□ No	Bleeding Problems	□ Yes	□ No	Anemia	□ Yes	□ No	Ulcers
□ Yes	□ No	Blood Disease	□ Yes	□ No	Radiation or Cobalt Treatments	□ Yes	□ No	Dizziness	□ Yes	□ No	Stroke
□ Yes	□ No	Nervous Disorders	□ Yes	□ No	Asthma or Hay Fever	□ Yes	□ No	Cancer	□ Yes	□ No	Pacemaker
□ Yes	□ No	Sinus Trouble	□ Yes	□ No	Venereal Disease	□ Yes	□ No	Tuberculosis	□ Yes	□ No	Latex Allergy
□ Yes	□ No	Biphosphinate Meds.	□ Yes	□ No	Phen-Fen						

Please Explain and "YES", or any other medical issues: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully, and to the best of my knowledge.

Date: Signed:

FOR DR. YEBISU:
I have reviewed the Patient's Medical History.

Date: Signed:

Dental History

kyinfo2012c.cdr

How would you describe your Dental Health? □ Excellent □ Good □ Fair □ Poor

Reason for this visit: _____

□ Yes □ No Are you in pain? If YES, how much? _____

□ Yes □ No Is it important to you to keep your teeth?

□ Yes □ No Do you feel nervous about Dental Treatment?

Have you ever had any of the following?

□ Yes	□ No	Periodontal (Gum) Treatment	□ Yes	□ No	Bleeding Gums
□ Yes	□ No	Orthodontic Treatment	□ Yes	□ No	Painful or Swollen Gums
□ Yes	□ No	Teeth removed (extracted)	□ Yes	□ No	Your bite adjusted
□ Yes	□ No	Loosening of Teeth	□ Yes	□ No	Jaw Clicking/Popping

IMPORTANT

Name of previous Dentist

Phone Number of previous Dentist

( )

City where previous Dentist is located

Date of last visit	Were you happy with this Dentist? □ Yes □ No

Comments?

□ Yes □ No Have you ever had an upsetting experience in a Dental Office?

Please explain: _____

□ Yes □ No Are you satisfied with the appearance of your teeth?

Please explain: _____

□ Yes □ No Is there anything else about Dental Treatment that bothers you, or is there anything else you want us to know?

Please explain: _____

kyinfo2012c.cdr

The undersigned hereby authorizes Dr. Yebisu to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yebisu to make a thorough diagnosis of my dental needs.

Date: Signed:

FOR DR. YEBISU:
I have reviewed the Patient's Dental History.

Date: Signed:

Acct # _____

FINANCIAL AGREEMENT

Patient _____

Responsible Party _____

Employer _____

Home # _____ Work # _____

Spouse _____

Spouse's Employer _____

Home # _____ Work # _____

Please check all methods of payment that apply for your dental care.

☐ **I DO NOT HAVE DENTAL INSURANCE**

☐ I can pay by ___Cash, ___Check, ___Bankcard (MC/VISA/AMEX/DISC) on each visit as treatment progresses.

☐ I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a **CareCredit* credit application, and that monthly finance charges may be involved.

☐ **I HAVE DENTAL INSURANCE**

☐ I elect to pay my deductible (or co-payment), and any portion of the costs my insurance does not pay by ___ Cash, ___Check, ___Bankcard (MC/VISA/AMEX/DISC) on each visit as treatment progresses.

☐ I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a **CareCredit* credit application, and that monthly finance charges may be involved. *CareCredit* is a separate line of credit to cover your entire dental needs. Approval takes less than 30 minutes, and there is no annual fee or prepayment penalty.

I realize that my insurance benefits can only be estimated, and that no insurance company will pay all treatment costs. I understand that I am responsible for all costs not paid by my insurance company within 60 days of the insurance claim submittals, and that interest may accrue on my account after this time.

I consent that my signature below may be kept on file for submittal of any insurance claim forms pertaining to my family's dental treatment.

Date _____ Signed _____

Ky

Ken Yebisu, D.D.S.

fa.lwp

Insurance & Financial Policy Disclosure

FEDERAL TRUTH-IN-LENDING CONSUMER CREDIT DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

I agree to pay Dr. Yebisu for professional services rendered. I understand that a 1.5% Finance Charge (18%APR) will be assessed on the Unpaid Balance after 30 days, and that this will be reflected on the billing statements I will receive. I also agree that if I default on any payment, the entire balance becomes due and payable immediately at the discretion of Dr. Yebisu's Office. I further acknowledge that I will be held responsible for any and all costs of collection.

Date_____ Name (print)_____

Signature_____

Ky

Ken Yebisu, D.D.S. 17122 Beach Blvd., #202 Huntington Beach, CA 92647 714/847-0790

Insurance & Financial Policy Disclosure

DENTAL INSURANCE

1. As a courtesy to you, we will complete and file insurance forms relative to dental treatment. We will provide all pertinent information to your insurance carrier, to help you derive the maximum benefits available.
2. Regardless of Insurance Coverage, *you* are directly responsible to us for the fees for services provided.
3. Your particular program may base its allowances on a fee schedule *which may not coincide with our office fees.*
4. Our office does NOT determine the benefits paid by your policy; our role is to provide the information the Insurance company uses to determine what benefits are paid.
5. You should know that Insurance Coverage rarely is 100%. Various programs usually cover from as little as 30% to as much as 80% of major procedures.
6. Financial arrangements for dentistry need to be made with our office *prior to treatment.* At the minimum, your estimated portion is due at the time of treatment.
7. This estimated portion is just that: ***an estimate.*** Once your insurance issues payment, you will be responsible for any balance remaining.
8. Although Insurance Companies are supposed to pay within 30 days of billing, they often take much longer. To minimize Finance Charges to your account, you are invited to contact the Insurance Company; they usually respond quicker to patient calls (as opposed to calls from the dental office).

PRE-AUTHORIZATIONS

1. Some Insurance plans include a "pre-determination" or "prior authorization" clause. When appropriate, we will submit a treatment plan for review by your insurance carrier.
2. Insurance Companies tell us that pre-determinations are NOT a guarantee of payment. It is an estimate only. Ultimately, you will be responsible for whatever Insurance does not reimburse.

Comments:

1. Most Insurance plans were not designed to be a "PAY-ALL". They are intended to be an AID to attaining optimum dental health.
2. There usually is a deductible involved, and a yearly maximum to be considered.
3. All policies have Exclusions and Limitations, that further reduce your benefits. We urge you to read your policy.

DENTAL HMO'S AND DMO'S

1. These plans are ***NOT*** insurance policies. ***NO*** forms are required, and *NO* claims are filed when service is rendered. Your HMO/DMO is NOT billed for services rendered.
2. These programs entitles you to discounts on certain services. Any co-payments for these services is due in full at the time of treatment. For Non-covered services, you are responsible for the full fee.

FINANCIAL POLICY

1. Whenever possible, you will be informed of our fees before the service is performed.
2. Financial arrangements for dentistry need to be made with our office *prior to treatment.*
3. For balances over 30 days, our office assesses Finance Charges. The finance charges are 1.5%/mo (18%APR).
4. We accept Cash, Check, and Charge (VISA, M/C, DISC, AMEX). For your convenience, we also offer Payment Plans (Dental Lines of Credit).
5. There is a Broken Appointment Fee of $40 for appointments canceled or otherwise not kept, without 48 hour notice.

Ky

Ken Yebisu, D.D.S.

I have read and received a copy of this Disclosure.

Date_____ Signature_____

instpol3.lwp

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____

Email: _____ Weight: _____

Gender: M F DOB _____

- **OVER 18 MILLION AMERICANS SUFFER FROM SLEEP APNEA**
- **PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS**
- **90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED**

Do you snore?	**Yes**	**No**
Do you have high blood pressure?	**Yes**	**No**
Have you gained weight and find it difficult to lose?	**Yes**	**No**
Do you have unexplained awakenings from sleep?	**Yes**	**No**
Do you awaken from sleep gasping for air or choking?	**Yes**	**No**
Do you notice frequent twitching or jerking of legs while asleep?	**Yes**	**No**
Do you feel your sleep is not refreshing or restful?	**Yes**	**No**
Do you have a headache upon waking in the morning?	**Yes**	**No**
Do you often lay in bed unable to fall asleep?	**Yes**	**No**
Do you wake up during the night and are unable to fall back asleep?	**Yes**	**No**
Do you feel fatigued or find it difficult to stay awake during the day?	**Yes**	**No**

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Prior Diagnosis:

Have you been previously diagnosed with sleep apnea?		**Yes**	**No**
If Yes:	When were you diagnosed approximately?	_____	
	Were you put on CPAP therapy for treatment?	_____	
	Are you still using your CPAP every night?	**Yes**	**No**

Insurance:

Do you have **Medical Insurance**? **Yes** **No**

If Yes what type: _____ HMO _____ PPO _____Other

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Never doze off, 1 = Slight chance of dozing, 2 = Moderate chance of dozing, 3 = High chance of dozing

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____

Doctor: _____ **Date:**_____

Phone: _____ **Fax:** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this Acknowledgment)

I have received a copy of this office's Notice of Privacy Practices.

Print Name _____ Date _____

Signature _____

Ky *Ken Yebisu, D.D.S.*