

Frank Seo, D.D.S., M.P.H
Woodbridge Dentistry

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name: _____ Birthdate: _____ Soc. Sec # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Sex: Male Female Status: Single Married Widowed Separated Divorced

Employer / School: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you? _____

PRIMARY INSURANCE

Subscriber Name: _____ Phone: _____

Relation to patient: _____ Birthdate: _____ Soc. Sec # _____

Subscriber Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Phone: _____

Group # _____ Subscriber/ Member ID # _____

Maximum Annual Benefit: _____ How much have you used? _____

ADDITIONAL INSURANCE

Subscriber Name: _____ Phone: _____

Relation to patient: _____ Birthdate: _____ Soc. Sec # _____

Subscriber Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Phone: _____

Group # _____ Subscriber/ Member ID # _____

Maximum Annual Benefit: _____ How much have you used? _____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last dental care: _____ Date of last x-rays: _____

Please check if you have had problems with any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth |
| <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Clicking or popping jaw |
| <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Other information about your dental health or previous treatment: _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Date of last visit: _____ Have you had any serious illnesses or operations? Y N

If yes, describe: _____

Are you currently under physician care? Y N If yes, describe: _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates: _____

Have you ever taken Fen-Phen / Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Please check if you had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Material allergies
(latex, wool, metal, chemicals) | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker/Heart surgery
<input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Swelling of feet/ankles |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Rheumatic/Scarlet fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/Abnormal bleeding | | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High blood pressure | | |

Are you currently taking any medications? If yes, list all: _____

Do you have drug allergies? If yes, list all: _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature _____ Date _____

Frank S. Seo, D.D.S.
4950 Barranca Parkway, Suite 309, Irvine, CA 92604
(949) 552-5055
www.irvinecosmeticdentist.net

APPOINTMENT POLICY

Your appointment time is reserved just for you. If you need to change a scheduled appointment, please contact us **at least two business days in advance**. Failure to notify us will result in a missed appointment charge of \$45.00.

INSURANCE INFORMATION AND AUTHORIZATION

This office will assist and process the necessary dental insurance forms for you. However, ***while we strive to obtain and provide accurate insurance information, it is not a guarantee of coverage. The anticipated payments from your insurance company are estimates only.*** You are responsible for insurance deductibles, estimated co-payments, and non-covered procedures on the day of services.

Your insurance policy is an agreement between you, your employer, and your insurance company. When you receive treatment, you agree to be directly responsible for all charges, including all charges not paid by insurance.

Most insurances have yearly deductibles and maximums, and in some cases, lifetime maximums. It is your responsibility to be aware of these maximums, and you will be responsible for any charges not covered by insurance.

Regarding secondary insurance: In many instances, secondary insurance do not cover the remaining balance after payment from the primary insurance. Therefore, we will bill the primary insurance and request the estimated co-payment on the day of service. After the primary insurance has made payment, we will provide you with necessary documentation that you can submit to the secondary insurance.

Because we submit most insurance claims electronically and indicate "Signature on File" on paper claims, a signed authorization must be maintained in the patient's file.

I fully understand the appointment policy, authorize payment of benefits, and agree to be financially responsible for all treatments provided.

Date: _____ Patient's Signature: _____