MEDICAL-DENTAL HISTORY FORM

Name ____
Last First Middle

Address: _________________________________City ______________ State ______ Zip Code_________

Secondary Address (**if applicable**): ____

Preferred Name: ____________________ SS#: _________________________ DOB:_____________

Sex: ________ Marital Status: __________

IF WE ARE UNAUTHORIZED TO LEAVE MESSAGES AT ANY OF THE NUMBERS OR E-MAIL ADDRESS LISTED BELOW PLEASE MARK HERE, OTHERWISE WE WILL ASSUME WE ARE ABLE. ☐

Home Phone: __________________ Work Phone: _________________ Cell Phone: _______________

E-Mail Address: _____________________________________

Medical Alerts: ____

Are you now or have you recently been under a physician's care? YES NO

Have you ever been a patient in a hospital or had any serious illness? Explain:

____

Check any of the following that you have had or suspected:

- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Arthritis
- ☐ Kidney/Bladder Trouble
- ☐ Stroke
- ☐ Lung Disease
- ☐ Asthma or Hay Fever
- ☐ Hepatitis or Jaundice
- ☐ Liver Disease
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Blood Disease
- ☐ Anemia
- ☐ HIV or AIDS
- ☐ Venereal Disease
- ☐ Prolonged Bleeding
- ☐ Blood Transfusion
- ☐ Mental Disorder
- ☐ Thyroid Disease
- ☐ Sinus Trouble
- ☐ Prosthetic Joint Replacement
- ☐ Cancer/Tumor/Radiation Treatment

Check any of the following that you are taking or have taken:

- ☐ Cortisone Drugs
- ☐ Steroids
- ☐ Anticoagulants
- ☐ Blood Thinners
- ☐ Fosamax
- ☐ Fen-phen
- ☐ Tranquilizers
- ☐ Sedatives

Are you taking other medications? Explain: _______________________________________

Are you allergic to or do you suffer ill effects from any of the following?

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Household Bleach
- ☐ Dental Anesthesia
- ☐ Latex
- ☐ Other ____

WOMEN ONLY:
Are you pregnant? YES or NO, If yes how many months? ______ Are you breast feeding? _______

Are you presently taking medicine of any kind routinely? (Birth control pills, shots,implants, hormone therapy, etc.)

Explain: ____

THE ABOVE INFORMATON IS TRUE TO THE BEST OF MY KNOWLEDGE.

RESPONSIBLE PARTY NAME (PRINT): ____

Signature:____ Date: ____________________

2241 AVENUE A, SUITE 7
YUMA, ARIZONA 85364

DENNIS R. WONG, D.M.D. PC
GENERAL DENTISTRY

TEL: 928.783.0636 FAX: 928.783.0054

APPOINTMENTS

1. Patients are seen by appointment. Emergencies and walk-ins will be seen as time permits.
2. We make every effort to see you at your scheduled time and appreciate you being on time for your appointments.
3. Patients failing to cancel or reschedule an appointment **24 hours in advance** will be subject to a $50.00 failed appointment fee.

FINANCIAL ARRANGEMENTS

1. Payment is required at time of service. We accept cash, personal checks (There is a $25 returned check fee), Visa, Master Card, Discover, and Care Credit (our payment program – if you are interested ask for an application)
2. Any month your account carries a balance you will receive a monthly statement which may also include outstanding insurance claims.
3. Should the account become 90 days over due and be referred to a collection agency, the undersigned agrees to pay the additional 40% collection fees, plus any costs, and interest charged by the collection agent. In addition should the account be referred to an attorney for collection the undersigned agrees to pay any reasonable attorney's fees, cost and interest charged as a result of a referral.
4. Our fees when quoted for treatment will be honored for 90days. Beyond that, fee may be adjusted to reflect any cost increases.

INSURANCE

1. Patients with insurance will have estimated co-payments due at time of treatment, (no exceptions), based on information your insurance has given us when we called.
2. As a courtesy to you, our office will submit a claim to your insurance and we will wait only 60 days for payment. Your total balance will be due within 90 days of your service.
3. **You are responsible for your dental bill regardless of what your insurance does or does not pay**

The undersigned has read and understands the above stated policies, agrees to abide by them, and accepts financial responsibility for themselves and their dependents for any dental fees incurred at this office.

Signature ______________________________________ Date ___________________

Patient's Name: _________________________________ Date ___________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEATH INFORMATION ABOUT YOU MAY BE USED AND DESCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practice, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14th 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all heath information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at anytime. For more information about our privacy practice, or for additional copies of this Notice, please contact us using the information list at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your heath information to Physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your heath information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in this Notice.

To Your Family and Friends: We must disclose your heath information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with payment for your healthcare, but only if you agree that we may so.

Persons Involving in Care: We may use or disclose health information to notify, or assist in the notification of (including Identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure o your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose heath information based on a determination using our professional judgment disclosure only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person's to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your heath or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of Inmate of patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your heath information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your heath information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your heath information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your heath information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (excepted in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your heath information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your heath information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Heath and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Heath and Human Services upon request.

We support your right to the privacy of your heath information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: **Dennis Wong**
Telephone: **928-783-0636** Fax: **928-783-0054**
E-Mail: **dennisrwong@roadrunner.com**
Address: **2241 S Avenue A Suit #7 Yuma Arizona 85364**

Dr. Dennis R. Wong D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practice

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- □ Individual refused to sign.
- □ Communications barriers prohibited obtaining the acknowledgement.
- □ An emergency situation prevented us form obtaining acknowledgement.
- □ Other (Please Specify)

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INSURANCE INFORMATION

Subscriber Name: ____
Last Name First Name Middle Name

SS#: ____________________ DOB: ___________ Relation to Patient:____________

Subscriber Employer: ____

Insurance Carrier: ____

SECONDARY INSURANCE

Subscriber Name: ____
Last Name First Name Middle Name

SS#: ____________________ DOB: ____________ Relation to Patient:____________

Subscriber Employer: ____

Insurance Carrier: ____

SIGNATURE ON FILE

Patients Name: ____
Last First Initial

I hereby authorize payment directly to ________Dennis R Wong, DMD_____________
of the dental benefits otherwise payable to me. (Dentist Name)

____
Signature (Insured Person) Date

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

DENNIS R. WONG, DMD is authorized to provide any insurance company(s), claim administrator(s), and counseling health care professionals, information concerning heath care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contact, in force on this date only, or for two years, whichever is shorter. I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

____
PATIENT OR AUTHORIZED PERSONS SIGNATURE DATE