PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____/_____/_____ (PLEASE PRINT) Phone: H (_____)_____C (_____)_____

PATIENT INFORMATION

Name _____ Email _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex □Male □Female Age _____ Birthday ____/____/_____ Social Security # ____/____/_____ □Single □Married □Other

Employer _____ Occupation_____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Whom may we thank for referring you? □Friend's Name _____□Insurance List □Newspaper □Websites _____

In case of emergency, who should be notified? Name_____ Phone _____ Email _____

FINANCIAL RESPONSIBLE PARTY INFORMATION (if different from above)

Name _____ Email _____
Last Name First Name Initial Preferred Name

Relationship to patient: □Spouse □Parent □Children □Other _____ Home Phone # (if different from above)(_____)_____

Address (if different from above)_____ City _____ State _____ Zip _____

Sex □Male □Female Birthdate ____/____/_____ Social Security # _____/____/_____

Employer _____ Occupation_____

Business Address _____ City _____ State _____ Zip _____ Phone _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____/_____/_____

Have you ever had any of the following? (Check boxes that apply):

□AIDS or other Immunosuppressive Disorders
□Allergies to Anesthetics
□Allergies to Medicine or Drugs
□Arthritis
□Artificial Heart Valves or Joints
□Back Problems
□Blood Disease
□Cancer
□Chemical Dependency
□Chronic Diarrhea
□Chemotherapy
□Circulatory Problems
□Diabetes
□Epilepsy
□Fainting
□General Allergies
□Glaucoma
□Headaches
□Heart Murmur
□Heart Problems
□Hepatitis, Jaundice or Liver Disease
□Hemophilia
□High Blood Pressure
□Low Blood Pressure
□Nervous Problems
□Mitral Valve Prolapse
□Pacemaker
□Psychiatric Care
□Radiation Treatment
□Recent Weight Loss
□Respiratory Disease
□Rheumatic Fever
□Sinus Problems
□Special Diet
□Stroke
□Swollen Neck Glands
□Tobacco Habit
□Thyroid problems
□Ulcer
□Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication? □ Yes □No If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

For Women Only: Do you suspect that you are pregnant? □ Yes □ No Are you nursing? □ Yes □No

Are you under the care of a physician? □Yes □No For what conditions?_____

Are you taking any medication at this time? □ Yes □ No If so, what?_____

Is there anything else we should know about your medical history? _____

The information on the previous page is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentists or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____/_____/_____ Signature _____

DENTAL INSURANCE INFORMATION

Dental Insurance Company (primary)_____Group# _____

Name of Insured _____ Birthdate ____/____/_____ Social Security # ____/____/_____

Dental Insurance Company (secondary)_____Group# _____

Name of Insured _____ Birthdate ____/____/_____ Social Security # ____/____/_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

And assign directly to __Dr. LU GAN__ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____ (initial) I have received a copy of the '"NOTICE OF PRIVACY PRACTICES". **You may refuse to initial this acknowledgement.

_____ _____
Date Signature

MINOR / CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

____ (initial) I have receipt a copy of the DENTAL FINANCIAL POLICY.

_____ _____
Date Signature

APPOINTMENT CHANGE POLICY

We have a policy of charging up to **$50** for missing or canceling an appointment with less than **48** hours of notice. If you have to cancel your appointment, please notify us as early as possible.

The purpose of this policy is to encourage all of our patients to take their appointments as seriously as we do. Doing so will help us maintain our schedule so that we can accommodate all of our patients.

Also, our appointments run on a tight schedule, so please notify us if you are going to be **15** minutes or more **late**.

We apologize for any inconveniences and sincerely hope that we can work together to satisfy everyone.

_____ _____
Date Signature