Christopher Yang DMD

PATIENT INFORMATION AND HEALTH HISTORY FORM

Thank you for choosing our office to assist you with your dental needs!

Please fill out both sides of this form to best of your knowledge.

Patient Information

First Name: MI: Last Name:

Mailing Address: _____
Street Apt/Suite

_____
City State Zip

Email Address:

Date of Birth: / / SSN: Gender:
*Recommended for billing insurance claims

Mobile Phone: Home Phone:
Our office uses email and text for appointment confirmation and billing purposes. To opt out of either service, please contact our office.

Occupation: Employer:

Emergency Contact: Phone: Relationship:

How did you hear about our clinic?

If completing this form for another person or if the patient is less than 18 years old, please fill out your name and relationship:

Name: Relationship:

Guarantor Information

If the insurance holder or person financially responsible for account is different than the patient, please fill out:

Name: DOB: / / SSN:

Dental History and Information

What is the reason for your visit today?

Date of last dental x-rays or exam:

Are you experiencing any dental pain or discomfort? □ Yes □ No If yes, please explain:

Please mark if any of the following applies:

- Do your gums bleed when you brush? □
- Do you clench or grind your teeth? □
- Do you have sores or growths in your mouth? □
- Does your jaw click, pop, or hurt? □
- Have you ever had periodontal (gum) treatment such as scaling and root planing? □
- Have you ever had problems with dental treatment in the past? □
- Have you ever had a reaction or problem with dental anesthesia? □
- Are you unhappy with your smile? □

Medical History

Physician's Name:

Date of last physical exam: / /

Preferred Pharmacy:

What is your normal blood pressure (systolic, diastolic)?

Please list all prescription and/or over-the-counter medication(s), vitamins, herbs, and/or supplements

_____

_____

	Yes	No
Do you use any form of tobacco product?	□	□
Do you use vaping products?	□	□
Do you use recreational drugs?	□	□
How many drinks do you have per week? _____		

	Yes	No
WOMEN ONLY: Are you:		
Taking birth control? What type? _____	□	□
Pregnant? If yes, # of weeks: _____	□	□
Nursing?	□	□

Medical History - Allergies

Are you allergic to or have had an allergic reaction to:

	Yes	No
Aspirin	□	□
Barbiturates, sedatives, or sleeping pills	□	□
Codeine or other narcotics	□	□
Latex (rubber)	□	□
Local anesthetics	□	□
Metals	□	□
Penicillin or other antibiotics	□	□
Sulfa drugs	□	□

examples include sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole (Erzole), sulfasala-zine (Azulfidine), glyburide (Diabeta), dapsone, sumatriptan (Imetrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide), and furosemide (Lasix)

Other: _____

Medical History - Surgical History

	Yes	No
Do you take antibiotics before dental appointments?	☐	☐
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐
Have you had any type of joint replacement surgery (i.e. hip, knee, shoulder, elbow, finger, etc)?	☐	☐
Have you had a heart valve replacement or heart surgery?	☐	☐
Have you had an organ or bone marrow/stem cell transplant?	☐	☐

If you answered yes to any of the above questions, please explain:

Medical History - Systems

Do you have, or have you been diagnosed with, any of the following conditions?

	Y	N	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired in the past 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus Trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Y	N	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood Transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV infection	☐	☐	☐
Lupus	☐	☐	☐

	Y	N	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice, or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Obstructive Sleep Apnea	☐	☐	☐
Do you use a CPAP machine?	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any other additional information or other conditions not mentioned above?

It is important for both the doctor and the patient to talk honestly about the patient's health before any dental treatment.
I have answered the above questions completely, accurately, and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

Christopher Yang DMD

For completion by the office

Comments:

Office Use Only: □ Medical Alert □ Premedication □ Allergies □ Anesthesia

Reviewed by: _____ Date: _____

Christopher Yang Dental – Patient Financial Agreement

Oral health is the foundation of our relationship and we strive to provide outstanding care for our patients.
We offer the following agreement and payment options.

For our patients with dental insurance:

We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- All patient copayments and/or patient portions are only an estimate. They are not a guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all out of pocket portions/copayments and deductibles.
- Insurance payments not paid after 45 days of billing will become your complete responsibility and must be paid in full.

For our patients without dental insurance:

Payment in full is due at the time of service, unless arrangements have been made prior to your scheduled appointment. Financing is available upon request. Please ask our office if you would like more information.

Our office honors fees for 6 months after a treatment plan is given. If any treatment has not been completed within 6 months, our fees are subject to change to the most recent fee schedule.

Statements/Finance Charges:

All patients with an outstanding balance will receive monthly statements. Balances older than 60 days are subject to collection fees and interest charges of ***1.5% per month***. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance.

Payment Options:

For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express, HSA/FSA, and CareCredit. There is a $35 fee for any checks returned due to insufficient funds.

CareCredit is available to help with patients finance larger dental or orthodontic cases. No down payment is required and payments can be made up to 6 months with no interest.

Missed appointments or short notice cancellations:

We understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice or no notice, a fee of $35 charge may be billed to your account. Please help us service you better by keeping scheduled appointments.

I understand my financial options and that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office regardless of insurance benefits. In the event my account becomes delinquent, I will be responsible for any collections, legal fees, and any other charges incurred to collect this account. I authorize Dr. Christopher Yang DMD and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand the financial agreement terms and policies and agree to follow them.

Signature of patient or responsible party: _____ Date: _____

Relationship to patient: _____

Dr. Christopher Yang DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Information

Name: _____ DOB: _____

Additional information if not already on file:

Address: _____

Telephone: _____ Email: _____

SECTION B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent and is available at the front desk. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, the revised Notice of Privacy Practices will be available at the office front desk. You may also obtain a copy at any time by contacting:

Contact Person: Christopher Yang
Telephone: 920-457-2410
E-mail: *dental@yangdmd.com*
Address: 1214 S 23rd St, Sheboygan, WI 53081

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

SECTION C: Patient/Relative HIPAA Consent

I understand that by signing below, I am giving my consent for Dr. Christopher K Yang and staff to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family members and/or persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Right to revoke: I understand I have the right to revoke this consent at any time by giving written notice to office staff.

Patient Signature: _____ Date: _____