ELKE CHEUNG
dentistry

Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ [ ] Male [ ] Female
[ ] Single [ ] Married [ ] Child Birth date: ____/____/____ Age: _____ SS #: _____
Home Address: _____ City _____ State _____ Zip _____
Home Phone: ( ) _____ Work: ( ) _____ ext _____
Cell: ( ) _____ E-mail Address: _____
Employer: _____ how long there? _____ Occupation: _____
Employer's Address: _____ City _____ State _____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date: ____/____/____ Relation: _____
Billing Address: _____ City _____State _____ Zip_____
Home Phone: ( ) _____ Work: ( ) _____ SS#: _____
Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[ ] Same as above Name: _____ Birth date: ____/____/_____
Employer: _____ Work Phone: ( ) _____ ext _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name: _____ Phone: ( ) _____ Group/Policy#: _____
Insured's Name: _____ Insured's Birth date: ____/____/____ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____
Secondary Insurance
Insurance Co. Name: _____ Phone: ( ) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ____/____/____ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

We send appointment reminders by e-mail and text. If you would like to opt out, please indicate here.
[ ] do not e-mail [ ] do not text message

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: ( ) _____

Do you have or have ever had any of the following? Please check those that apply:

☐Allergies/Hay Fever	☐Diabetes (Type I/II)	☐Heart Surgery*	☐Rheumatic Fever
☐Anemia	☐Epilepsy or Seizures	☐Hepatitis	☐Rheumatism
☐Angina	☐Neurological Problems	☐High Blood Pressure	☐Sickle Cell Disease
☐Arthritis	☐Fainting or Dizziness	☐HIV*/AIDS	☐Sinus Problems
☐Artificial Joints*	☐Jaundice	☐Kidney Problems	☐Surgical Shunt*
☐Artificial Heart Valves*	☐Frequent Cough	☐Liver Problems	☐Stroke
☐Asthma	☐Glaucoma	☐Mental Disorders	☐Thyroid Problems
☐Breathing Problems	☐Heart Disorder	☐Mitral Valve Prolapse*	☐Tuberculosis
☐Cancer	☐Heart Infection*	☐Osteoporosis	☐Ulcers
☐Chemical Dependency	☐Heart Murmur*	☐Radiation Treatment	☐Venereal Disease
☐Chemotherapy	☐Heart Pacemaker*	☐Respiratory Problems	☐Excessive bleeding from cut or extraction

*This condition may require antibiotic pre-medication for certain dental procedures

Need to premedicate? YES/NO if yes, what is the name of the antibiotic? _____

Do you have any health problems that were not listed above or that need further clarifications? YES/NO
If yes, explain: _____

Are you now under the care of a physician? YES/NO
If yes, explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? YES/NO
If yes, explain: _____

Are you taking any medications or herbals? YES/NO
If yes, list: _____

Are you allergic to any medications or substances? YES/NO If yes, please check box below:
Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other: _____

Do you smoke or use tobacco? How much/How long? _____

Do you use Alcohol? How often/How much? _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

Signature _____Date _____

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.
Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.
Please help us better understand your dental health needs and goals by answering the following questions:

Date of last dental visit: _____ Name of previous Dentist: _____

☐Teeth Sensitive to cold,heat, sweets or pressure	☐Unfavorable experience	☐Frequent Blisters on lips/mouth
☐Bleeding gums – how long? _____	☐Extraction Complication	☐Use Electric Toothbrush
☐Food impaction	☐Clenching/Grinding	☐Texture of toothbrush _____
☐Bad Breath/Unpleasant taste	☐Pain around ear	☐Frequency of Brushing _____
☐ Excessive Thirst/Dry Mouth	☐Wear Nightguard	☐Use dental floss
☐Previous periodontal treatment	☐Orthodontics/Braces	☐Interdental cleaners

1. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
2. My greatest fear about dental treatment is: [ ] **discomfort/pain** [ ] **expense** [ ] **time it takes**.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable.**
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor.**
6. I would say that my main concerns with my dental health are:

_____

7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [ ] **Yes** [ ] **No**

Please check which statement below best represents the level of dental health you wish to achieve.
(Some people begin at one level and progress to a higher level over time.)

HEALTH LEVEL I - **Emergency Care**
[ ] I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

HEALTH LEVEL II - **Maintenance Care**
[ ] I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

HEALTH LEVEL III - **Comprehensive Care**
[ ] I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

HEALTH LEVEL IV - **Comprehensive & Cosmetic Care**
[ ] I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least 48 hours advanced notification so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. **A fee of $55.00 is charged for patients who miss or cancel an appointment without 48-hour notice.**

FINANCIAL POLICY

Thank you for choosing Elke Cheung DMD PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Discover or American Express

We offer a 5% courtesy discount to patients who pay for treatment, not covered by insurance, with cash at the time treatment is presented and accepted. The discount does not apply to co-payments or deductibles.

- Convenient Monthly Payment Plans[1] from CareCredit.

Please note:

Elke Cheung DMD PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] However, our office does not guarantee payment or coverage from your insurance carrier. It is your responsibility to keep our office updated with your most current insurance information, and to verify that you have coverage for services provided at this office. The patient or Guarantor is the responsible party for all dental services provided. Dental insurance is a benefit with limitations and should not be expected to take care of all costs. Your portion will be estimated and you will be responsible for all charges not fully paid by your dental insurance carrier.

Elke Cheung DMD PC charges $30 for returned checks. We charge a $15 late fee on balances over 60 days.

A 40% collection fee will be added to balances that are unpaid and are sent to our collection agency.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. Elke Cheung, DMD. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize Dr. Elke Cheung, DMD to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. Elke Cheung, DMD.

I understand and will comply with office **Appointment Policy.**
I understand and will comply with the office **Financial Policy**.
I understand and agree to the General **Consent to Treatment.**
I authorize the **Release of Information.**

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND 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

Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 5/1/2009 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 health 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 any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, 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 except those described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved 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 of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing 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 to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the 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 the protected health information of inmate or patient under certain circumstances.

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

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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 health 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 the cost of supplies and labor of copying. 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 $1.00 for each page, $20.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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 of this 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 health 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 health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health 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 you 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 health 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 Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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 Officer: Elke Cheung DMD PC
Telephone: 203-846-0400
E-mail: office@drcheungsmiles.com
Address: Elke Cheung DMD PC, 43 North Avenue, Norwalk, CT 06851