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

[ ]self [ ]Name: __________________________ Birth date: ____/____/____Relation:____________________

Billing Address: ______________________________ City ______________State _______ Zip__________

Home Phone: ( ) __________________ Work: ( ) _________________ SS#: ____________________

Employer: ____________________________ How long there? _______ Occupation: __________________

SPOUSE INFORMATION

Name: ____ Birth date: ____/____/_____

Employer: __________________________________ Work Phone: ( ) __________________ ext _______

DENTAL INSURANCE INFORMATION

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	☐ Chemotherapy	☐ Heart Surgery*	☐ Respiratory Problems
☐ Anemia	☐ Diabetes (Type I/II)	☐ Hepatitis	☐ Rheumatic Fever
☐ Angina	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis	☐ Neurological Problems	☐ HIV*/AIDS	☐ Sickle Cell Disease
☐ Artificial Joints*	☐ Fainting or Dizziness	☐ Kidney Problems	☐ Sinus Problems
☐ Artificial Heart Valves*	☐ Frequent Cough	☐ Liver Problems	☐ Surgical Shunt*
☐ Asthma	☐ Hearing Deficiency/Loss	☐ Mental Disorders	☐ Stroke
☐ Autoimmune Disorder*	☐ Heart Disorder	☐ Mitral Valve Prolapse*	☐ Thyroid Problems
☐ Breathing Problems	☐ Heart infection*	☐ Orthopedic Pins/Posts*	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur*	☐ Osteoporosis	☐ Ulcers
☐ Chemical Dependency/Addiction	☐ Heart Pacemaker*	☐ Radiation Treatment	☐ 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 had any surgeries or procedures, 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 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 scans 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: ____

☐ Sensitivity to cold, heat, sweet, pressure	☐ Unfavorable experience	☐ Frequent Blisters on lips/mouth
☐ Bleeding gums	☐ 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	☐ Frequency of Flossing ___________
☐ Previous periodontal treatment	☐ History of 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 currently.

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, 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, to achieve long-term stable, yet esthetic, dental health.

INSURANCE COVERAGE INFORMATION

It is important that you are aware of your insurance coverage. There are plans with which we participate however many of these plans have variations in coverage as well as multiple rules and regulations. Additionally, some companies arbitrarily select certain services that they will not cover.

Your insurance coverage is a contract between you/your employer and your insurance company. **We have no influence on what is covered, and it is your responsibility to be aware of coverage. You are financially responsible for any services not covered and will be billed accordingly.** We are required by the insurance company to collect all copays and deductibles as indicated on any explanation of benefits.

We will make every effort to help you with your insurance coverage but cannot guarantee any eligibility, coverage, or payment amounts. Your cooperation in providing accurate information ahead of time is needed to ensure you receive the insurance coverage to which you are entitled.

initial ________

FINANCIAL POLICY

You, the patient, or the guarantor, assume financial responsibility for all dental treatment provided to you or your minor. You understand that payment is expected on the date services are provided. You understand that it is ultimately your responsibility to understand your insurance contract and what you are responsible for financially. ***You understand that if your insurance plan does not pay for services as expected you are still responsible for payment***. All copays are non-refundable. In the case of an account credit balance after receipt of applicable insurance policy payments a refund will be issued to you or the guarantor of the account.

You understand that the office may release your information to your insurance company to e-file claims as a courtesy and receive payment directly from them. Please contact us if you make any changes to your dental coverage, so that we may keep accurate and current records of your account. ***40 days is the office's maximum waiting period for insurance payment***. After this time, you understand that you are responsible for any remaining balances and that a late fee may be assessed on your account if payment is not made in a timely manner***. Further failure to pay will result in the account being sent to collections***.

To streamline our billing system and avoid large balances from accumulating, **a credit card is required to be kept on file for every family**. Your card will be stored securely, and our office will NOT have access to your card information as only the last 4 digits will show in our system. All charges will be run through this card unless you provide an alternative method of payment when payment is due. You will be notified by the preferred contact method of any balance prior to charging your card. By signing you are authorizing our office to charge your credit card for copays, deductibles, co-insurance, non-covered services, late and no-show fees.

initial ________

CANCELLATION AND MISSED APPOINTMENT POLICY

To be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to make your appointment. This will allow us to offer your reserved appointment to a patient in urgent need of treatment and reschedule you for another appointment date. Any hygiene appointment(s) not cancelled at least **48 hours** in advance is subject to a **$55** cancellation fee, any treatment appointment(s) with the doctor not cancelled at least **48 hours** in advance is subject to a **$110** cancellation fee. We cannot reschedule your appointment until the fee is paid. Continued cancellations and no-shows may result in dismissal from the practice.

initial ________

AUTHORIZATION AND CONSENT

General Consent for Treatment
I agree and consent to a dental examination by Dr. Elke Cheung. 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 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.

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 _____________

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

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 reviewed 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 prevented us from obtaining acknowledgement

☐ Other (Please Specify)