CHARLIE H. HONG, DMD, MSD
Practice Limited to Endodontics

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PATIENT INFORMATION

DATE _____

_____ ☐ M ☐ F
NAME (LAST, FIRST, MI)

☐ SINGLE ☐ MARRIED
☐ MINOR ☐ OTHER BIRTH DATE _____ SSN _____

_____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP

_____ _____
HOME PHONE MOBILE PHONE

_____ _____
WORK PHONE EXT BEST PLACE TO CALL

_____ _____
OCCUPATION EMPLOYER

_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUT OFFICE?

GUARANTOR INFORMATION

_____ _____
RESPONSIBLE PARTY NAME (IF NOT SELF) RELATIONSHIP TO PATIENT

☐ SINGLE ☐ MARRIED
☐ MINOR ☐ OTHER BIRTH DATE _____ SSN _____

_____
STREET ADDRESS (IF DIFFERENT FROM PATIENT)

_____ _____ _____
CITY STATE ZIP

_____ _____
HOME PHONE WORK PHONE

_____ _____
OCCUPATION EMPLOYER

EMERGENCY CONTACT INFORMATION

_____ _____
NAME RELATIONSHIP

_____ _____
HOME PHONE WORK PHONE

HEALTH HISTORY

Place a mark if you have had any of the following conditions:

- ☐ Anemia
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Blood Disorder
- ☐ Cancer / Tumor / Chemotherapy
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive / AIDS
- ☐ Immune Problems
- ☐ Jaw Pain
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained
- ☐ Other (please specify): _____

Women Only:

- ☐ Are you taking FOSOMAX?
- ☐ Are you pregnant? If so, how many weeks? _____
- ☐ Are you nursing?

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Do you pre-medicate? ☐ YES ☐ NO if yes, name of antibiotic: _____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

APPOINTMENTS: Failed appointments are a loss to everyone. Your appointment time is reserved especially for you and failure to show prevents another from receiving dental care. Therefore, we reserve the right to charge for appointments broken without 48 hours' notice.
PAYMENTS: We regret that we cannot bill. Payment is expected at the time of service. Payment may be made by cash, check, credit card, or approved payment plans. If you have dental insurance which may cover part of the cost of treatment, and wish to be eligible to file through our office, you must have provided us with your insurance booklet. You will be expected to pay your estimated portion and your deductible at the time of service.
INDEBTEDNESS: There is a $25.00 service charge for all returned checks. A 1 ½% finance charge (18% annually), as permitted by law, will be added to any balance over 60 days (this includes outstanding insurance). In the event of default, any unpaid balance will be turned over to a collection agency. You will be responsible for all collection costs and attorney's fees (50% of your outstanding balance), which will be added to the indebtedness.

I, the undersigned, certify that all information provide is complete and accurate to the best of my knowledge. I have read and agree to the policies above.

SIGNATURE **X** _____ DATE _____

DENTAL INSURANCE

Primary Dental Insurance

Subscriber Relationship to Patient (if self, skip this section)

Name (last, first, mi)

☐ Single ☐ Married ☐ Minor ☐ Other Sex: ☐ Male ☐ Female

Birth Date SSN/ID

Occupation Employer

Insurance Co.

Group No.

Secondary Dental Insurance

Subscriber Relationship to Patient (if self, skip this section)

Name (last, first, mi)

☐ Single ☐ Married ☐ Minor ☐ Other Sex: ☐ Male ☐ Female

Birth Date SSN/ID

Occupation Employer

Insurance Co.

Group No.

Assignment and Release

I, undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Dr. Charlie H. Hong, DMD, MSD** all insurance 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 insurance submissions.

Responsible Party Signature **X** _____

Relationship to Patient_____ Date_____

OFFICE USE ONLY

Primary Dental Insurance

Insurance Co. Effective Date

Group No. ID No.

Yearly Max Deductible Benefit Year

Endo Coverage Waiting Period Frequency Limit

Date Remaining Benefit Remaining Deductible

Date Remaining Benefit Remaining Deductible

Date Remaining Benefit Remaining Deductible

Secondary Dental Insurance

Insurance Co. Effective Date

Group No. ID No.

Yearly Max Deductible Benefit Year

Endo Coverage Waiting Period Frequency Limit

Date Remaining Benefit Remaining Deductible

Date Remaining Benefit Remaining Deductible

Date Remaining Benefit Remaining Deductible