SUNRISE DENTAL STUDIO

8352 Ritchie Hwy. Pasadena, MD 21122
410-647-3595

PATIENT REGISTRATION

PATIENT NAME: _____ DATE OF BIRTH: _____

GUARDIAN (If applicable): _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____SEPARATED _____WIDOWED

HOME PHONE: _____ CELL PHONE:_____

WORK PHONE:_____E-MAIL:_____

PREFERED CONTACT METHOD: _____ PHONE _____ EMAIL _____ TEXT

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

PRIMARY INSURANCE INFORMATION

PRIMARY POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY: _____ PHONE NUMBER: _____

GROUP NUMBER: _____ ID NUMBER: _____

SECONARY INSURANCE INFORMATION

SECONDARY POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY: _____ PHONE NUMBER: _____

GROUP NUMBER: _____ ID NUMBER: _____

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MEDICAL HISTORY SUMMARY

Patient Name: _____ **Date of Birth:** _____

Phone number (Cell): _____**(Home):** _____**(Work):** _____

Email: _____ **Best Contact Method:** _____

Address: _____

Question	Explanation
Have you had **ALLERGIC** or ADVERSE reactions to LATEX gloves or Latex adhesive.	
Have you had **ALLERGIC** or ADVERSE reactions to any medications such as Penicillin, Clindamycin, Tylenol, Ibuprofen, Aspirin, local anesthesia or other medications?	
Do you have any **CARDIOVASCULAR** issues such as Heart Attack, Stroke, Chest Pain, Angina Pectoris, Heart Surgery, Heart Murmur, Infective Endocarditis, artificial heart valves or other? Please explain:	
Do you have or have you ever had **High or Low Blood Pressure**? Please explain:	
Do you have or have you ever had any of the following **INFECTIOUS DISEASES** such as Hepatitis, Tuberculosis, HIV/AIDS or any other? Please explain:	
Have you ever had **Chemotherapy**, **Radiation**, or other surgical or other treatment for **CANCER**? If yes please explain:	
Do you have or have you had any **ENDOCRINE** conditions such as Diabetes, insulin or non Insulin dependent, Thyroid disorder, Adrenal disorder or any other conditions?	
Do you have or have you ever had any **RESPIRATORY** conditions such as Asthma, COPD/Emphysema, Tuberculosis or other conditions?	
Do you have or have you ever had **GASTROINTESTINAL** conditions such as Stomach Ulcers, Ulcerative Colitis, Acid Reflux or other associated conditions?	
Do you have or have you had any **KIDNEY** conditions such as reduced Kidney function, Dialysis or other kidney conditions?	
Do you have or have you ever had any **LIVER** conditions such as Hepatitis, Cirrhosis or other Liver conditions?	

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Do you have or have you had any **NEUROLOGIC** conditions such as Seizures, Epilepsy, Stroke, Fainting, Migraines, Neuropathy/Neuralgia or other neurologic conditions?	
Do you have any **ORTHOPEDIC** conditions such as arthritis, neck or spinal injuries, prosthetic joints (Hip, knee), or osteoporosis? Please explain:	
Do you have any disease, conditions, or problems not addressed above?	
Do you require **ANTIBIOTIC PROPHYLAXIS** for prosthetic joint, artificial heart valve, or infective endocarditis? Please explain:	
Are you on any **BLOOD THINNER** such as aspirin, Eliquis (apixaban), Warfarin (Coumadin), Xarelto (Rivaroxaban), Pradaxa (Dabigatran)?	
Are you taking or have you ever taken any oral/IV bisphosphonates such as **Fosamax** (Alendronate), **Boniva** (Ibandronate), **Actonel** (Risedronate), **IV Reclast** (Zoledronic Acid)? Please explain:	
Do you have a history of substance abuse? (alcohol, drugs and if you have received treatment). Please explain:	
Do you smoke?	
Do you use any recreational drugs?	
WOMEN: Are you pregnant, trying to get pregnant, or nursing? Please explain:	
Are you taking any medications? Please list	

Consent: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature: _____ **Date:** _____

Doctor Signature: _____

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved in treatment)
- Obtaining payment from third party payers (e.g. insurance companies)
- The day-to-day healthcare operations of the practice

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the office of Dr. Jennifer Yau, DDS, LLC reserves the right to change the terms of this notice from time to time and that I may contact the practice at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. I also understand that I am not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Patient/Guardian Signature: _____

I approve releasing my information to the following people: (e.g. spouse, parents, guardian, family)

Spouse Name: _____ Phone Number_____

Parents Name: _____ Phone Number _____

Guardian Name: _____ Phone Number _____

Other Name: _____ Phone Number _____

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Assignment and Release

I hereby authorize payment directly to Sunrise Dental Studio, the office of Dr. Jennifer Yau, DDS for all insurance benefits otherwise payable to Dr. Yau for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid or not paid by insurance. I authorize the above doctor and/or provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and health care operations. I authorize the use of this signature on all insurance submissions.

Financial Policy

I understand any account with balances over 30 days from the initial statement date will be subjected to 5% interest up to three consecutive months. If not paid within 90 days of our initial statement, you agree to pay Dr. Jennifer Yau liquidated damages calculated as twenty-five percent (25%) of the current principal balance on your account in addition to attorney's and legal fees. I understand Sunrise Dental Studio, the office of Dr. Jennifer Yau will send my account to collections after 3 statements sent and after 3 phone call attempts to collect payments. I also understand that I am billed a $35.00 return check fee for any checks returned for insufficient funds.

Office Policy

A minimum charge may be billed for missed or canceled appointments without prior notification of 48 hours. I understand that failure to give a 48-hour notice that I cannot keep a reserved appointment may result in a missed appointment fee of $70.00 per hour appointment and, should this happen 3 times, will result in dismissal from the practice.

Our office understands last-minute cancellations are inevitable due to work arrangement or illness, however after the 3rd inevitable cancellation in a 12-month period, a minimum charge of $70.00 will be billed.

I understand after our office reserves the right to refuse appointments for late cancellations as well as failure to attend. Please remember that once an appointment is made, this time is reserved especially for you.

Consent for Use/Disclosure of Health Information

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this consent.

I, the undersigned, understand and agree to the policies stated above. I certify that the information on this form is accurate, to the best of my knowledge.

_____ _____

Patient Name (Printed) **Date**

Signature: _____