Liberty Dental

Patient information

First name: _____ Last name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

******Please provide as much information as possible for appointment confirmation purposes******

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Email address: _____

******What is your contact preference?*** _____ ***

Birth Date: _____ Age: _____ Soc. Sec: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Employment Status: □ Full Time □ Part Time □ Retired Student Status: □ Full Time □ Part Time

Employer: _____ Emergency Contact (Name/Phone#) _____

How did you find our office? (Referral Source)_____

Responsible Party (if someone other than patient)

First name: _____ Last name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____

Birth Date: _____ Soc. Sec: _____

Relationship to patient □ Self □ Spouse □ Child □ Other

□ Responsible party is also the Policy Holder for Patient
□ Primary Insurance Holder
□ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Primary Insurance Co: _____

Name of Insured: _____

Employer: _____

Relationship to patient: □ Self □ Spouse □ Child □ Other

Insured SSN: _____

Insured Birth Date: _____

Secondary Insurance Co: _____

Name of Insured: _____

Employer: _____

Relationship to patient: □ Self □ Spouse □ Child □ Other

Insured SSN: _____

Insured Birth Date: _____

Medical History

Physician's Name: _____ Address: _____ Office Phone: _____

1. Are you under medical treatment now?	Y	N
2. Have you ever had major surgery or been hospitalized for any reasons within the last five years?	Y	N
3. Any changes in your health in the past year?	Y	N
4. Are you taking any medications including OTC medications? If yes, please list them: _____	Y	N

(Medical history continued on next page)

Liberty Dental

Do you have, or have you ever had any of the following: Circle all that apply

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	Artificial Heart Valves
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	AIDS/ HIV
Hepatitis	Tuberculosis	Sexually Transmitted Disease	None	

Do you have, or have you had, any problems with the following: Circle all that apply

Sinus Trouble	Asthma	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney Problems	Jaundice
Digestive Problems	Colitis	Stomach Ulcer	Hemophilia	Neurological Problems
Fainting	Seizures	Epilepsy	Mental Health Problems	Depression
Abnormal Bleeding	Clotting Problems	Phlebitis	Anemia Transfusions	Cancer
Tumor(s)	Cyst	Biopsy	Biopsy	Arthritis
Artificial Joints	Muscle/Bone Disease	Use tobacco	Use alcohol	Use controlled substances

***ATTN TO WOMEN:	Are you pregnant?	Y	N	Are you nursing?	Y	N

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa Drugs	Aspirin	Local Anesthetics
Codeine	Nickel/Other Metals	Latex	Other _____

Dental History

Previous Dentist's Name & Address _____ Office Phone _____

1. What is your primary dental complaint? _____
2. When was your last exam and x-rays taken? _____ Last cleaning? _____
3. Do you have a fear or significant anxiety to dental treatment? If so, please explain _____

Do you have, or have you had, any problems with the following: Circle all that apply

Gum bleeding	Gum disease	Sensitivity	Toothache	Jaw pain
Sores/lumps in mouth	Grind teeth	Bite lips/cheeks	Prolonged bleeding	Head injury
Neck injury	Jaw injury	None		

Patient Confidentiality

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed that *Notice of Privacy Practices* contains a more complete description of the used and disclosure of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, exception to the extent that you have taken action relying on this consent. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children during the period of such dental care to third party health practitioners or other professionals. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents. Our office does send out recall cards and confirm appointments on a daily basis. If you prefer not be contacted by mail, please let us know.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. During treatment, I will report any changes in my health, illness or hospitalization, and additions/changes in medication to those listed above. I consent to the use of appropriate medication and therapy as deemed necessary. I agree to follow the instructions of the doctor or his staff member. I fully understand that using local anesthetic gents embodies certain risks. I understand that a fee will be charged for the duplication of any component of my dental record when requested by myself or a designated representative. Any fee for dental x-rays is for interpretations only and does not constitute patient ownership of the x-rays themselves.

Patient Name (Print) _____ **Signature** _____ **Date** _____

James Chun DDS PA

9014 Glenwood Avenue Raleigh, NC 27617 Phone No. (919) 571-7777

Scheduling Appointments and Cancellation Policy

It is requested that you will arrive promptly for each appointment scheduled. If you are unable to keep an appointment please give our office **(2) working days** notice. There will be a $30 fee applied to your account after your **first** broken appointment, and any subsequent broken appointments, that must be paid prior to your next scheduled appointment. It is also asked that when scheduling family appointments (two or more patients) that you do not reschedule without at least **(2) working days** notice. Please be advised if there are more than (2) broken appointments for a single patient or (2) rescheduled appointments for a family we will no longer schedule future appointments for the patient(s). We provide an answering machine during non-business hours to serve you better in keeping and rescheduling appointments

Despite careful scheduling, emergencies can cause delays. We try our very best to stay on time. If your appointment time is affected due to an unforeseen emergency, we'll try to notify you. We know that your time is valuable, too. You will receive the same quality dental care no matter how our schedule is running.

Insurance and Payment Options

We are not responsible for any exclusion that may cause your claim to be denied. If your claim is denied it is your responsibility to pay promptly on the treatments. Please inform us if there are any changes in your insurance, address, or phone numbers so that we may update our records and keep your account current.

Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. All deductibles and co-pays are due **at the time of service**. It is also your responsibility to be aware of your deductibles and insurance plan policies. Payment to our office remains your responsibility, regardless of how much your insurance handles your claim(s).

In order to assist you with your dental care investment, we accept cash, checks, all major credit cards, and Care Credit. If you present a check for insufficient funds, you will be charged a $40.00 fee. Additional checks will not be accepted until the non-sufficient check and related fees have been paid.

If you have an outstanding balance on your account beyond 120 days, your account **will** automatically be turned over to collections. The responsible party will absorb all fees associated with the collection proceedings. While in collections no appointments will be scheduled for you with the exception of emergency cases.

Patient Agreement

Patients who carry dental insurance do hereby agree to assign benefits that he/she is eligible to receive for the care rendered in this office to James J. Chun D.D.S. and you understand and agree that you will be responsible for any expenses not paid by your insurance company.

I HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS OUTLINED ABOVE.

Signature _____ **Date**_____

Print Name _____

LIBERTY DENTAL
9104 Glenwood Avenue
Raleigh, NC 27617
919-571-7777

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reasons:

  _____

- **Other:** _____

  _____

Prepared By _____

Signature _____

Date _____