Patient's Name ____

Name of person completing form *(if different from patient)* and relation to patient: ____________________

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of safe and quality care. All information you provide will be kept confidential.

Please answer by CIRCLING Yes (Y) or No (N) for each individual question

Are you in good health? **Y** **N** Date of last check up by physician: ___________

Has there been any change in your general health in the past year? **Y** **N**

Are you currently under a physician's care? **Y** **N**
If so, reason: ____
Treating Physician's Name: ____

Have you had any serious illness, operations, or hospitalizations? **Y** **N**
If so, describe and give approximate dates ____
____

Have you ever had intravenous sedation or general anesthesia? **Y** **N**
Were there any adverse side effects? **Y** **N**

DO YOU HAVE OR HAVE YOU EVER HAD?

Heart disease that was detected at birth? **Y** **N**

Rheumatic fever, Rheumatic heart disease or **Mitral Valve Prolapse?** **Y** **N**

Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? **Y** **N**

Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough? **Y** **N**

Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorders) **Y** **N**

Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? **Y** **N**

Stomach ulcers or Intestinal problems **Y** **N**

Thyroid Disease (hypothyroidism, tumor)? **Y** **N**

Diabetes **Y** **N**

Arthritis? (which joints?) **Y** **N**

Kidney Disease **Y** **N**

Liver Disease (jaundice, hepatitis)? **Y** **N**

HIV/AIDS **Y** **N**

⇒**Please continue on next page**

Glaucoma? (increased eye pressure) **Y** **N**

Implants/artificial joints anywhere in you body? (heart valve, hip, knee)? **Y** **N**

Radiation (X-ray treatment for cancer) in head and neck region **Y** **N**

Any diseases, drugs or transplant operation that has depressed your immune system? **Y** **N**

Frequent or recurring mouth sores? **Y** **N**

Recurrent infection of any kind? **Y** **N**

Sinus or nasal problems? **Y** **N**

Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? **Y** **N**

Do you generally tolerate dental treatment well? **Y** **N**

ARE YOU TAKING OR USING ANY OF THE FOLLOWING?

Antibiotics **Y** **N**

Thyroid medications **Y** **N**

Antihistamines, decongestants **Y** **N**

Steroids **Y** **N**

Tranquilizers, Antidepressants? **Y** **N**

Blood thinners (baby aspirin)? **Y** **N**

High blood pressure/heart medications? **Y** **N**

Cholesterol reducing drugs **Y** **N**

Stomach or GI medications (antacids, etc.)? **Y** **N**

Marijuana, cocaine / other "recreational" drugs **Y** **N**

Medication for osteoporosis? **Y** **N**

Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers **Y** **N**

Weight reduction pills or diet aids (over the counter or "natural" products) **Y** **N**

Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements **Y** **N**

Any other regular medications, pills, supplements or drugs **Y** **N**

⇒PLEASE LIST ALL CURRENT MEDICATIONS HERE____

____

____

⇒Please continue on next page

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

Local anesthetic (Novocaine-like drugs)? **Y N** **Latex? Y N** **Iodine? Y N**

Penicillin, Amoxicillin, Cephalosporins (Keflex)? **Y N** Other antibiotics **Y N**

Barbiturates, sedatives? **Y N** Codeine, narcotics or opioids? **Y N**

Aspirin, ibuprofen, NSAIDS, or other pain medicines? **Y N**

Other allergic reactions? **Please list**: ______________________________ **Y N**

____

Do you have hay fever, frequent skin rashes, etc.? **Y N**

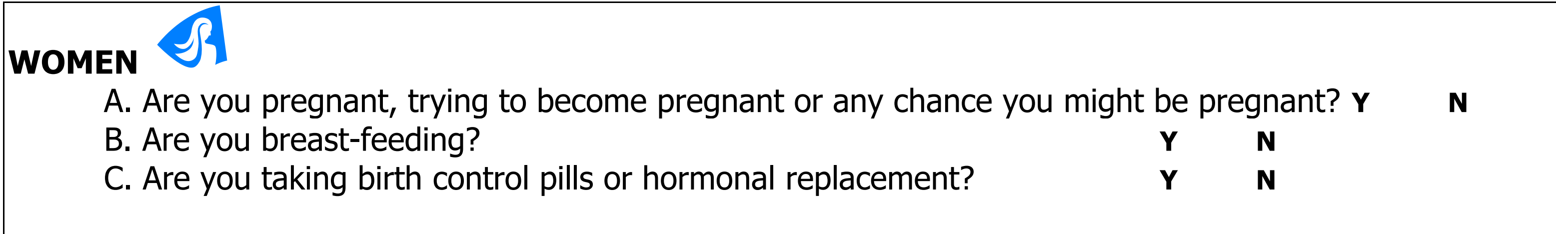
Do you use alcohol? How much per day? ____________________ **Y N**

Do you smoke or use "smokeless or spit" tobacco? **Y N**
What product and how many per day? ______________________ How many years? ______

Are you, or have you ever been in a drug or alcohol recovery program? **Y N**

Do you have any disease or problem that you think the doctor should know about? **Y N**

Do you wish to talk to the doctor in private about anything? **Y N**



WOMEN

A. Are you pregnant, trying to become pregnant or any chance you might be pregnant? **Y N**
B. Are you breast-feeding? **Y N**
C. Are you taking birth control pills or hormonal replacement? **Y N**

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment and general health. To the best of my knowledge, the above is complete and accurate.

________________ ______________________________
Date Signature of person completing Health History

⇒**Please continue on next page**

Patient Name: ______________________ ☐ Married ☐ Domestic Partners ☐ Single ☐ Child ☐ Other

☐ Male ☐ Female

Social Security #: ______________________ **Driver's License** # ______________________

Birth date: ____________________ E-mail address: ______________________

Phone (Home): ______________ (**Work):** ______________ Ext.: _____ Best time to call: _________

Preferred contact method (home number, work number, e-mail?) ______________________

Cell &/or Pager: ______________ ______________

Address: ______________________ ______________

Residence -No Post Office Box

Apartment #

______________________ ______________ ______________

City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care; and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance (dental payment assistance plans) understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per year) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate is valid for a period of thirty (30) days from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

______________________ Date: _________ Relationship to Patient: ______________

Signature of patient, parent or guardian

⇒**Please continue on next page**

Name(s) & phone numbers of person(s) to contact in case of emergency:

____

____

____

Referral Information

Name of person or office referring you to our practice: ___________________________________

☐ Another patient, friend or relative ☐ Website ☐ Angie's List

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Person Financially Responsible for Account *(If different than patient)*

Name: ____

Social Security #: __________________________ Birth Date:___________________

Phone (Home): __________ (Work): __________ Ext.: ______ Best time to call: _______

Billing Address: _______________________________________ ________________

Street Apartment/Suite#

____________________________ ______________________ __________

City State Zip Code

Employment Information

For Person Financially Responsible for Account

Employer (Firm) Name: ____________________________ Occupation: ___________________

Address: ____ ________________

Street Suite#

____________________________ ______________________ ________________

City State Zip Code

Consent for Purposes of Treatment,
Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Hasan Yap, DDS** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills. I understand that diagnosis or treatment of me by **Hasan Yap, DDS** and **Robert L. Smith, DDS PA** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Hasan Yap, DDS & Robert L. Smith, DDS PA** are *not* required to agree to the restrictions that I may request.
However, if **Hasan Yap, DDS** agrees to a restriction that I request, the restriction is binding on **Hasan Yap, DDS** and **Robert L. Smith, DDS** , and **Lori Albe, DMD.**

I have the right to revoke this consent, in writing, at any time, except to the extent **that Hasan Yap, DDS , Robert L. Smith, DDS PA** or **Lori Albe, DMD** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Hasan Yap, DDS** Notice of Privacy Practices prior to signing this document. **Hasan Yap, DDS** Notice of Privacy Practices has been provided to me (if requested). The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Hasan Yap, DDS** This Notice of Privacy Practices also describes my rights and the duties of **Hasan Yap, DDS** with respect to my protected health information.

Hasan Yap, DDS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________ ______________
Signature of Patient or Legal Representative Date

____
Print Legibly Name of Patient

____
Relationship to Patient (Parent, legal guardian)

Payment is due the date services are rendered

Our office accepts cash, Visa, MasterCard, Discover, American Express and checks (with valid personal identification). We also offer financing through GreenSky. In many situations, GreenSky offers twelve month financing with no interest.

As a courtesy to you, we will gladly submit information to your insurance company in order for you to receive benefits according to your policy. ***We do not, however, accept insurance payments or assignments***. You are responsible for payment of your dental services. If you have any questions regarding the fee for your proposed treatment, our financial secretary will be happy to discuss it with you.

If full payment is not received within ninety days, accounts are dismissed from our office and automatically submitted to a collection agency. A $25.00 delinquency fee will be added to the final account balance.

For the treatment of a child under the age of 18 of divorced parents, we consider the parent bringing the child to our office to be responsible for payment of his/her services.

A substantial amount of time is reserved for surgical cases such as dental implants. A deposit of ½ of the treatment fee will be required to reserve the appointment time, with the balance due the day of the procedure.

Professional fees quoted will be honored for thirty days.

I have read, understood and agreed to the above policies. I acknowledge that it is my responsibility to pay for any incurred fees in full. My signature will also serve as authorization for the release of information if needed.

Please circle your method of payment: **VISA MC AMEX DISCOVER CASH CHECK**

Patient or Legal Guardian: ____
Signature

____
Please print legibly

Date: ____