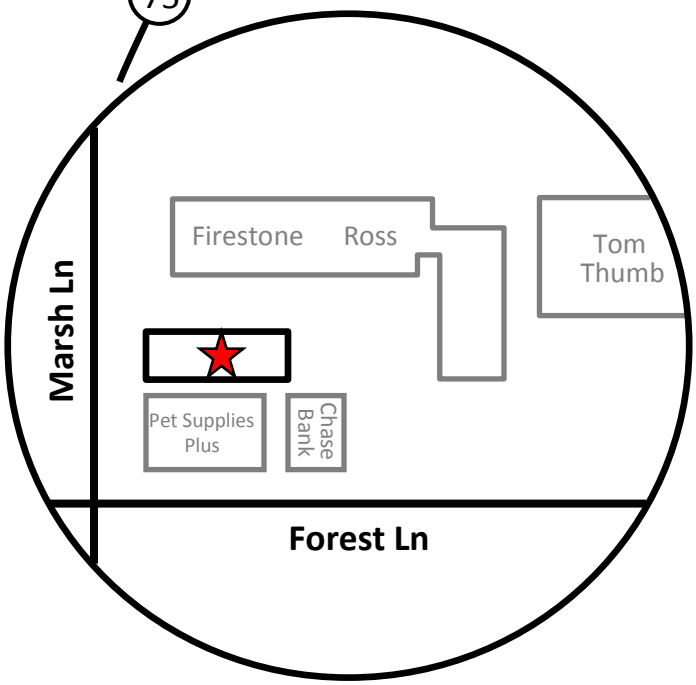
sunny smile DENTAL



Please call us if you need additional directions at 972-481-8800.

Sunny Smile Dental
11888 Marsh Lane Suite 105
Dallas, TX75234

We look forward to meeting you!

Welcome to our dental family! Thank you for trusting us with your dental needs.

PATIENT INFORMATION

Date: _____/_____/_____ Male ☐ Female ☐

Last Name:_____ First Name:_____ Preferred name:_____

Birth date: _____/_____/_____ Age: _____ S.S. #: _____-_____-_____ DL #:_____

Home Address:_____

Apt/Condo # _____ City:_____ State: _____ Zip:_____

(select/**click** appropriate box) Single ☐ Married ☐ Divorced ☐ Separated ☐

E-Mail:_____

Hm #: (_____) _____-_____ Cell #: (_____)_____-_____ Wk #: (_____)_____-_____

Where & when are the best times to reach you? (Ex: Work, Noon, Text)_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

GUARANTOR/GUARDIAN INFORMATION

Name:_____ Relation to Patient:_____

Hm #: (_____) _____-_____ Cell #: (_____)_____-_____ Wk #: (_____)_____-_____

Employer:_____ Occupation:_____

Birth date: _____/_____/_____ S.S. #: _____-_____-_____

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, is there someone who lives near you that we could contact?

Name:_____ Relation to Patient:_____

Hm #: (_____) _____-_____ Cell #: (_____)_____-_____ Wk #: (_____)_____-_____

PHYSICIAN'S INFORMATION

Name of physician:_____

Phone #: (_____) _____-_____ Fax #: (_____) _____-_____ Specialty_____

Address:_____

Suite # _____ City:_____ State: _____ Zip:_____

sunny smile DENTAL

Medical History

Are you allergic to any of the following medications?

- ☐ Aspirin
- ☐ Barbiturates, Sedatives or Sleeping Pills
- ☐ Codeine or Other Narcotics
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ **NONE**

Please list all medications/over-the-counter or herbal supplemental drugs you are taking at this time:

_____

_____

Please indicate the following diseases or medical conditions you may currently have and/or have experienced in the past:

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints*
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defects
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Kidney Problems
- ☐ Liver disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sickle Cell Disease/Trait
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Diseases (STD)
- ☐ **NONE OF THE ABOVE**

*This condition may require antibiotic premedication

Have you ever been hospitalized? _____ Please state reason and date: _____

WOMEN (Check One): ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ **NONE**

Dental Questionnaire

1. Chief complaint/reason for visit: _____
2. If tooth pain, please rate 1 (minimal pain) – 10 (worst pain) _____ ☐ Cold ☐ Hot ☐ Sweets ☐ Pressure
3. When was your last dental exam? _____ When was your last professional cleaning?_____
4. Have you ever experienced any of the following:

- ☐ Bad breath
- ☐ Biting edges of teeth wearing down
- ☐ Bleeding, tender, or irritated gums
- ☐ Brushing too hard
- ☐ Changes in how your teeth come together
- ☐ Chipped teeth
- ☐ Difficulty opening or closing your mouth
- ☐ Food getting packed in between teeth
- ☐ Gum recession (lowering of gum levels)
- ☐ Orthodontic treatment (Braces)
- ☐ Missing teeth
- ☐ Soreness in the jaws
- ☐ Teeth Whitening
- ☐ Trauma in your lower face
- ☐ Traumatic dental experience
- ☐ Use of tobacco products
- ☐ **NONE OF THE ABOVE**

5. Is there any additional information you feel we need to know?_____If yes, please explain. _____

_____

Please carefully review the following information. ***Initial*** *by each statement and sign at the bottom. Please feel free to ask any questions you may have pertaining to this form and any office policies.*

Cancellation/Late Arrivals Policy

_____ **I understand this office has a CANCELLATION POLICY in which I am required to give a minimum 48 hour notice of change in appointment in order to prevent a cancellation fee of $25.**

_____ **I accept complete responsibility for my appointments even though I will receive a courtesy call approximately 2 days prior to my appointments. I will contact Sunny Smile Dental should my contact information change in order to facilitate such reminders.**

Financial Policy

_____ **I understand any insurance fee quoted is an *estimate* of payment based on the information provided by the insurance company, but does not guarantee full payment of the quoted fee.**

_____ **I understand that *I am responsible for payment at the time services are rendered*, unless prior financial arrangements had been made. I also understand this office files my insurance as a courtesy, but I am ultimately responsible for any co-payments, deductibles, and remaining balances not covered by insurance.**

_____ **I understand that any returned checks are subject to an accounting fee of no more than $35.**

Authorization and Consent

_____ **I certify that the information I have provided to Sunny Smile Dental is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to update this office to any changes in my medications and medical status.**

_____ **I authorize Dr.Sung-Hee Lee, DDS to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.**

_____ **I authorize and request my insurance company to pay my benefits directly to Dr.Sung-Hee Lee/ Sunny Smile Dental.**

_____ **I have received a copy of this office's NOTICE OF PRIVACY PRACTICES. (You may refuse to sign this acknowledgement.)** OFFICE USE ONLY: Reason acknowledgement could not be obtained: _____

The undersigned hereby authorizes Sunny Smile Dental to take x-rays, study models, photographs, or any other diagnostics aids deemed appropriate by Dr.Sung-Hee Lee, DDS to make a thorough diagnosis of the patient's dental needs and give permission for such items to be used for the purposes of research, education, or publication in professional journals. I also authorize Dr.Sung-Hee Lee, DDS to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with_____ (*patient name*) and further authorize and consent that Dr.Sung-Hee Lee, DDS choose and employ such assistance as she deems fit. I acknowledge that there are no guarantees, expressed or implied, as to the result of any procedures or dental treatments performed. I also understand there are risks involved with every dental procedure including, but not limited to, the use of anesthetics, as well as the risks of not having the recommended treatment performed.

Patient/Parent/Guardian Signature: _____ Date _____/_____/_____

11888 Marsh Lane Suite 105
Dallas, TX 75234

(972) 481-8800
www.drsunnysmile@gmail.com

Office Cancellation Policy

As a courtesy, our office will attempt to contact you at your number on file approximately 2 days prior to your appointment. It is your responsibility to keep your information current with our office. We ask that all patients be responsible for their appointment times and contact our office at least 48 hours prior to any cancellations or changes. Broken appointments or short term cancellations are unfair to patients who need appointments. ***Repeated broken appointments and short term cancellations will be subject to a $25 fee and/or dismissal from the practice.*** Late arrivals will be worked into the schedule if time permits and/or may be re-appointed to another day. After 2 violations of our policy, patients will no longer be offered preferred scheduling times. Please remember that we do provide work and school excuses for daytime hours.

Notice of Privacy Practices

Our Legal Duty:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect August 1, 2007, 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 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 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.

Patient Rights

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 practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request by contacting our front desk personnel.

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 August 1, 2007. 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.

Restrictions:
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 explaining 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.

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 of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us by contacting the Privacy Officer of this Practice. You may also submit a written complaint to the office for civil rights. We will provide you the address to provide your complaint with the office for civil rights 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 the Privacy Officer or with the Office for Civil rights

Privacy Officer: Mary Thao Ambrose
11888 Marsh Land Suite 105
Dallas, TX 75234
(P) 972-481-8800 / (F) 972-481-8802

Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Ave. S.W.
Room 509F, HHH Building
Washington, DC 20201

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare. For Example:

Treatment:
We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Appointment Reminders:
We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcards, or letters).

Payment:
We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provider performances, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization:
In addition to our use of your health information for treatment, payment, or healthcare operations, 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 authorizations while it was in effect. Unless you give us a written authorization, we cannot use your health information for any reason except those described in this notice.

To your Family and Friends:
We must disclose your heath information to you as described in the Patient Rights Section of this notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 location, your general condition, or death. If you are present then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure, in the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and 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.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written permission.

Required by Law:
We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

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 health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected health information of an inmate or a patient under certain circumstances.