



Patient Registration Form

Name: _____ Birth date: _____ Age: _____ SS# _____ date: _____

Occupation _____ Work # () _____ Marital Status: Single/ Married/ Divorced/ Widowed

Mobile # () _____ Home # () _____ Email: _____

Home Address : _____ Zip: _____

Person responsible for Acct: _____ Relationship: _____ Mobile # () _____

Who told you about us? _____

Do you have Dental insurance? Yes / No With _____

If so, who is the policy holder? Name: _____ DOB: _____ SSN: _____

Are you currently having dental problems? _____

Circle yes or no to the following questions:

Are you now taking?

- 1. Are you under the care of a physician..... Yes No
- 2. Have you ever had high blood pressure..... Yes No
- 3. Has a physician ever said you have heart trouble..... Yes No
- 4. Do you have Mitral Valve Prolapse..... Yes No
- 5. Do you have artificial joints..... Yes No
- 6. Have you had an abnormal bleeding following a cut or extraction..... Yes No
- 7. Has a physician or dentist ever said you have cancer..... Yes No
- 8. Are you allergic to Penicillin, Novocain, Codeine or any other medicine..... Yes No
If so what? _____
- 9. Is the patient allergic to anything other than medicine..... Yes No
If so what? _____

- 1. Drugs for high blood pressure? Yes / No
- 2. Drugs for sleep? Yes / No
- 3. Cortisone, steroids or ACTH? Yes / No
- 4. Anticoagulants or blood thinners? Yes / No
- 5. Tranquilizers or sedative? Yes / No
- 6. Antibiotics? Yes / No
- 7. Insulin? Yes / No
- 8. Please list any medications you are currently taking _____

Do you have or had ever had or ever had?

- 1. Rheumatic fever..... Yes No
- 2. Heart disease or Pacemaker..... Yes No
- 3. Anemia, leukemia or low platelets... Yes No
- 4. Epilepsy or convulsions..... Yes No
- 5. Asthma or hay fever..... Yes No
- 6. Tuberculosis..... Yes No
- 7. Diabetes? How long?..... Yes No
- 8. Kidney trouble?..... Yes No
- 9. Liver trouble or jaundice..... Yes No
- 10. Thyroid trouble or goiter..... Yes No
- 11. Syphilis..... Yes No
- 12. Fainting or dizziness..... Yes No
- 13. Glaucoma..... Yes No
- 14. Arthritis..... Yes No
- 15. HIV AIDS..... Yes No
- 16. Stroke?..... Yes No
- 17. Stomach ulcer?..... Yes No
- 18. Heart Murmur?..... Yes No
- 19. Prostate trouble..... Yes No
- 20. Hepatitis?..... Yes No
- 21. Eczema or hives?..... Yes No
- 22. Psychiatric treatment?..... Yes No
- 23. Are you pregnant?..... Yes No

I understand that payment is due at the time of service. I will pay today by:
CASH CHECK CREDIT CARD

I verify that the preceding information is true. I authorize release of information to my insurance company. I will allow Heungjoo Sung DDS and his associates to discuss my conditions with my physician(s) and to request medical information from them. I authorize the office of Heungjoo Sung, DDS to obtain and verify a credit report. I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practice"

Initial _____ Date _____



Dear patients,

Due to our increase of No Show and Cancellations in the same day, we were having a hard time to provide the best service to those who confirm and keep their appointments. To serve you better, we created a new policy for cancellations and confirmations. Please read carefully and sign below. We appreciate your cooperation! Thank You!

Cancellation Policy

I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to appointments.

I understand that failure to keep a scheduled appointment will result in an appointment fee of \$25.

Confirmation Policy

Please respond to our confirmation call/text 3 days prior to appointment to ensure we can keep your scheduled appointment.

X

Signature of Patient, Parent or Guardian

Date: _____



TRUE LOVE DENTAL

Dr. Henry Sung, D.D.S.
Tel: (301) 834-6441 Truelovedental@gmail.com
610 9th Ave, Brunswick, MD 21716

Cancellation and Reschedule of Appointments

I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to the appointment. I understand that failure to keep a scheduled appointment may result in a missed appointment fee of \$25.

However, if we are able to fill your appointment spot with less than 48 hour notice, you will not be charged.

Consent for Services and Financial Information

I hereby authorize True Love Dental to take x-rays, models, photographs and other diagnostic aids deemed appropriate by True Love Dental to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize True Love Dental to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

Financial Information: As a courtesy, this office will help prepare and submit your insurance forms. However, I understand that any fees not covered by my insurance are my final responsibility. By signing this form, I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

I understand that any fees estimated provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment 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 in cash at the time of service. ***A service charge of 18% per year will be charged to my account on an unpaid balance or the account will be sent to collection agency unless previously written financial arrangements are made. I understand that 3rd party financing options such as **MORE Credit and Deneffits** are available to assist with payments. I understand that in order to be approved for a MORE credit plan that a credit check will be administered (with Deneffits a credit check is not required). By signing this form, I authorize a credit check to be administered if I am asking for credit to be extended to me.

I understand that in the event that I default in the payment of fees due to True Love Dental, I will be responsible for all expenses incurred by True Love Dental including, but not limited to attorney fees, collection expenses, discretionary cost and court costs associate with collection outstanding fees. I also understand that negative payment information may be reported to credit agencies.

X _____

Signature of Patient, Parent or Guardian

Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

- First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Email Confirmation
- Text Message to my Cell Phone Work Phone Confirmation
- Home Phone Confirmation **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Email Confirmation
- Text Message to my Cell Phone Work Phone Confirmation
- Home Phone Confirmation **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Phone Message **Any of the Above**
- Text Message **None of the Above** (opt out)
- Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

Please *print* name of Patient

Please *sign* Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because
- Other (please describe) _____

Signature of Privacy Officer _____

CUSTOMIZED TREATMENT AND PRESENTATION QUESTIONNAIRE



Patient Name:	
Reason for visit:	Approximate date of last dental visit:

What is your primary concern you'd like us to address today?

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/or pain to fix down the road?

Yes No

Do you consider yourself more of a reactive person—someone who would rather wait to deal with any issues after they develop, even if that means costing you more time, visits, money and/or pain to fix down the road? Yes No

Do you have a high dental anxiety or fear when visiting the dental office for treatment? Would you like us to discuss sedation options that can keep you as comfortable as you'd like to be but also make you remember as little about your visit as you want? Yes No

Do you prefer to pay your bill in full or would you rather look at breaking your bill out into monthly payments over time, either at a low interest or 0% interest rate?

What do you value most in a dental office? **Please write answer below.**

Cosmetic - You most value how your teeth look. Want them straight. Want them white.

Function - You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side or area. No food or drink should be off limits to you.

Comfort - You most value NOT being in pain or having any tooth or gum sensitivities. Example: I can't eat this anymore because it hurts or is sensitive.

Longevity - You most value the ability to have your natural teeth forever. You wish to have the work you have done in the chair to last as long as possible.

What is the most important objection or obstacle you have to visiting a dental office? **Please write answer below.**

No objections or obstacles - I come faithfully every 6 months and value my dental health. Fear-Of pain. Noises. Environment. Past experiences.

Time - Night schedule. Getting appointments to suit your schedule. Not able to take off work, etc. Getting in and out of office quickly.

Have NOT had a sense of urgency - Nothing really hurts so haven't seen need to go to dentist in years or something has been hurting at some level for a while but I've been able to live with it.

Budget - Knew I needed a lot of work, didn't have money to address any issues found.

No Trust - Felt you were told you needed treatment you didn't need. Felt ripped off. Bad previous experience. Didn't give me any data to support treatment they recommended.

Do you prefer to pay off your balances over time or pay them in full so nothing is owed? _____

Do you prefer to break your appointments up into smaller visits and schedule out over time? _____

Do you prefer to get any necessary treatment done today, if possible, as getting into the office is a challenge for you?
