CUSTOMIZED TREATMENT AND PRESENTATION QUESTIONNAIRE

TRUE LOVE DENTAL

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?

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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:

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? _____		

Are you now taking?

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	15.	HIV AIDS.....	Yes	No
2.	Heart disease or Pacemaker.....	Yes	No	16.	Stroke?.....	Yes	No
3.	Anemia, leukemia or law platelets...	Yes	No	17.	Stomach ulcer?.....	Yes	No
4.	Epilepsy or convulsions.....	Yes	No	18.	Heart Murmur?.....	Yes	No
5.	Asthma or hay fever.....	Yes	No	19.	Prostate trouble.....	Yes	No
6.	Tuberculosis.....	Yes	No	20.	Hepatitis?.....	Yes	No
7.	Diabetes? How long?.....	Yes	No	21.	Eczema or hives?.....	Yes	No
8.	Kidney trouble?.....	Yes	No	22.	Psychiatric treatment?.....	Yes	No
9.	Liver trouble or Jaundice.....	Yes	No	23.	Are you pregnant?.....	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				

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**_____

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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 hours notice, you will not be charged

Confirmation Policy

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

Consent for Services

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 diagnose of my/my child's dental needs. Upon such diagnosis, I authorize True Love Dental to preform 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.

X_____ **Date:**_____

Signature of Patient, Parent or Guardian

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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 preformed without previous financial arrangements, must be paid in cash at 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 a collection agency unless previously written financial arrangements are made. I understand 3rd party financing options such as ***MORE Credit and Denefits*** are available to assist with payments. I understand that in order to be approved for a MORE credit plan that a credit check must 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 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_____ Date:_____

Signature of Parent or Guardian

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

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

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work 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
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

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

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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 _____