Welcome to Oak Tree Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Patient Information

Date_____ Home Phone (____) _____ Cell Phone (_____) _____
Name_____ SS# / Patient ID#_____
(Last name) (First name) (M/I)
Address_____ ____ E-mail_____
City_____ State_____ Zip_____
Sex □ M □ F Age_____ Birth Date _____
Patient Employer/School_____ Occupation_____
Employer/School Address_____ Employer/School Phone_____
Whom may we thank for referring you? _____
In case of an emergency who should be notified? _____ Phone (___)_____
Emergency contacts relation to patient _____

Primary Dental Insurance Information

Person Responsible for Account_____
(Last name) (First name) (MI)
Relation to Patient_____ Birth date_____ SS# /ID#_____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (___) _____
Insurance Company _____ Contact # _ (____) _____
Group #_____ Subscriber #_____
Name of other dependents covered under this plan_____

Additional Dental Insurance Information

Is patient covered by additional insurance? □ Yes □ No
Subscriber Name_____ Relation to Patient_____ Birth Date_____
Address (if different from patient) _____ Phone # (___) _____
City_____ State_____ Zip_____
Subscriber Employed By _____ Business Phone (___) _____
Insurance Company_____ Soc. Sec. # _____
Insurance Contact # _____ Group #_____ Subscriber # _____
Names of other dependents covered under this plan_____

Dental History

Reason for Today's Visit_____ Date of last dental care _____
Former Dentist_____ Date of last dental x-rays _____
Previous Dentist's Address_____ Phone _____

Check (√) if you have had problems with any of the following:

□ Bad Breath
□ Bleeding Gums
□ Clicking/Popping Jaw
□ Food collection between teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Circle any of the following about which you would like more information

Whitening Bonding Braces Implants Fixed replacement teeth Porcelain veneers
TMJ problems Gum problems Sonic Toothbrushes Sensitive teeth

Medical History

Name of Medical doctor _____ Dr.'s Phone # (____) _____
Have you been in the hospital in the past two years? Yes No
(Women) Are you currently pregnant? Yes No Due date_____ Nursing? Yes No
Do you smoke or use smokeless tobacco products? Yes No

Please circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Hepatitis
Heart Problems	Tuberculosis	Liver Disease
Heart Attack	Asthma	Drug Addiction
Angina Pectoris	Sinus Trouble	Hemophilia/Bleeding Disorders
High/ Low Blood Pressure	Diabetes	Cold Sores
Heart Murmur	Thyroid Disease	Canker Sores
Rheumatic Fever	Cancer	Epilepsy or Seizures
Artificial Heart Valve	Chemotherapy	Fainting or Dizziness
Heart Pacemaker/Defibrillator	Cortisone Treatment	Nervousness
Mitral Valve Prolapse	Pain in Jaw Joints	Psychological Treatment
Kidney Trouble	Latex Allergy	AIDS or HIV
Dialysis	Artificial Joint	Immune Disorders
Stroke	Colon Disorders	Anemia
Chemical Dependency	Cough, Persistent	Radiation Treatment
Skin Rash	Headaches	Penicillin Allergy

List any drug allergies you have:_____
Is the Allergic reaction anaphylactic ? ( ) yes, ( ) no. Please describe reaction: _____

Do you have any other unlisted health conditions? _____

What medications are you currently taking? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signature of Patient (over 18) or Parent _____
Date_____

ASSEMENT AND RELEASE

I verify that I, and/or my dependents have insurance coverage with _____
(Name of Insurance Company(ies)
and assign directly to Dr. Benhur Kang all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents to the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.
Your have the right to revoke this Consent at anytime by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature of Patient (over age 18) or Parent_____
Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** from Oak Tree Dental and that I have read, or had the opportunity to read if I so chose, and understood the **Notice**. (*A copy of the Notice can be found on the table in reception area or ask the receptionist for a personal copy.*)
Signature or Patient or Legal Representative: X _____Date_____

Oak Tree Dental Office Policies

WELCOME to our office. Your oral health directly affects your body health and we believe that healthy smiles are the gateway to a healthy body. We feel privileged that you have selected our office for your dental care and are excited in caring for all of your dental needs.

- **Office hours:** Our office is open by appointments only Tuesday – Friday (9am-5pm) and every other Saturdays (8:30am-12pm).
- All children under the age of 18 must be accompanied by a parent or legal guardian for the entire duration of treatment.
- **Appointments:** Your appointment time is reserved exclusively for you. We make every effort to be flexible with our schedule, but if you are more than 15 minutes late for your appointment, we may ask you to reschedule your appointment. We request a 24 hour advanced notice if you are unable to keep your appointment. We realize that unexpected events can happen. After your second missed appointment, a $25 fee will be assessed to your account if proper notice was not given. Saturday appointments are in high demand. If you miss two Saturday appointments without notice, future Saturday appointments will not be offered.

Oak Tree Dental Financial Policies

- We believe that decisions about your dental treatment should be made by you and your dentist, utilizing your insurance benefits to maximize and not dictate your oral health and well being.
- **Payment for dental services is due when checking in** for your dental appointment. We accept cash, personal checks, debit cards and most major credit cards. For your convenience, we provide third party financing through Care Credit.
- We file dental insurances as a courtesy to our patients. Due to the intricacies of insurance plans, we can only ESTIMATE your cost of treatment and copayments. We, at no time, guarantee what your insurance covers. As a courtesy, we will bill your insurance company for dental services and allow 30 days for them to render payment. You are then responsible for any balance that your insurance company has not paid due to any reasons including: policy termination or changes in your policy. The remaining balance is to be paid in full.
- MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment so that we may best be able to determine your benefits.

Patient signature for receipt of office policies: _____
Date: _____