PETER J LEE, DDS

FAMILY AND COSMETIC DENTISTRY

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name	Social Security Number	Driver's License and State	Birth date	Gender: Male / Female
Home Address	City	State	Zip	
Marital Status: Single / Married / Divorced / Separated / Widowed	Email Address	Cell Number	Home Phone	
Primary Insurance Company: INSURANCE BENEFITS VERIFIED ALREADY BY OFFICE	Group #	Member ID #		
Secondary Insurance Company: INSURANCE BENEFITS VERIFIED ALREADY BY OFFICE	Group #	Member ID #		

Responsible Party

Name INSURANCE BENEFITS VERIFIED ALREADY BY OFFICE	Social Security Number	Home Phone
Home Address	City, State, Zip	Birth date
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	Relationship to patient	
Responsible Person's Employer INSURANCE BENEFITS VERFIED ALREADY BY OFFICE	Occupation	Work Phone
Business Address	City, State, Zip	

Spouse's

Spouse's Name INSURANCE BENEFITS VERIFIED ALREADY BY OFFICE	Social Security Number	Birth date
Spouse's Employer INSURANCE BENEFITS VERIFIED ALREADY BY OFFICE	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City, State, Zip	

How do you hear about our office?

Referred by a Friend/Relative	Yelp	Insurance Plan	Live Near the Office	Web Site
Other	Google	Walk-In	Direct Mailing	Sign By Building

If you were referred, whom may we thank for referring you?

Consent

I will answer all health questions to the best of my knowledge. *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature	Date	*Relationship to Patient*

Agreement to pay

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to arid become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the-agreed upon fee schedule. Payment Preference

Cash/Check on day of treatment	Credit Card	Debit Card
Signature		Date

There may be a $50 charge for any missed appointments or appointments not cancelled at least 48 hours before the appointment time.

Patient's Dental Health

Why have you come to see us today? (e.g.: checkup, consultation, etc.)		
Previous Dentist	Last Visit	Date of Last Cleaning
Reasons for Changing Dentists:		
Have you had any problem with past dental treatment?		
Are you nervous about seeing a dentist? Yes No If Yes, Please tell us why?		
How often do you brush?	Do you floss? Yes No	How Often?

Please check each that applies

I clench or grind by teeth during the day or while sleeping.	My gums bleed while brushing or flossing.	I like my smile.
I prefer tooth-colored fillings.	I avoid brushing part of my mouth due to pain.	My gums feel tender or swollen.
I have problems eating.	I have had orthodontics.	I have had a facial or jaw injury.
I want my teeth straightened	I want my teeth whiter.	
What Are you dental priorities? (e.g. appearance, dental health, etc.)		

Patient's Medical History

I consider my Health to be (please check one): Excellent Good Fair Poor

Do you have or have you had any of the following?

1. Heart disease	22. Liver Disease	**Doctor Notes Only:**
2. Heart Murmur/Mitral Valve Prolapse	23. Jaundice	
3. Stroke	24. Hepatitis Type	
4. Congenital Heart Lesions	25. Diabetes	
5. Rheumatic Fever	26. Excessive Urination and/or Thirst	
6. Abnormal Blood Pressure	27. Infectious Mononucleosis ("Mono")	
7. Anemia	28. Herpes	
8. Prolonged Bleeding Disorder	29. Arthritis	
9. Tuberculosis or Lung Disease	30. Sexually Transmitted/Venereal Diseases	36. AIDS
10. Asthma	31. Kidney Disease	37. Immune Suppressed Disorder
11. Hay Fever	32. Tumor or Malignancy	38. Hearing Loss
12. Sinus Trouble	33. Cancer/Chemotherapy	39. Fainting Spells
13. Epilepsy/Seizures	34. Radiation/Therapy	40. Glaucoma
14. Ulcers	35. History of Drug Addiction	41. History of Emotional or Nervous Disorders
15. Implants/Artificial Joints: Hip-Knee	Other	WOMEN
16. I smoke or use chewing tobacco. Yes No - if yes, how much per day? How many years?		42. Are you taking birth control medication?
17. I have consumed alcohol within the last 24 hours.		43. Are you or could you be pregnant?
18. I usually take an antibiotic prior to dental treatment.		44. Are you taking or ever taken Oral Bisphosphonate For Osteoporosis?
19. Have you ever taken Fen-Phen or Redux?		
20. I have had major surgery. Year Type of operation		
21. Do you have any other medical problem or medical history NOT listed on this form?		

Are Allergic to any of the following?	Please list all medications you are currently taking:	
44. Aspirin/Ibuprofen		
45. Sulfa Drugs / Sulfites /Sulfides		
46. Penicillin		
47. Codeine		
48. Latex, Metals, Plastics	Physician's Name	Phone
49. Local Anesthetics (Novocain)	Address	Fax
50. Other Medications? Which ones?		

In the event of an emergency, please contact:

Name	Relationship	Phone
Name	Relationship	Phone

	Patient's Signature	Date
	If Patient is a Minor, Parent/Guardian Signature	Date

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Financial Policy

We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Payment is due on the date of service. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept Cash, Check, Visa, MasterCard, American Express, and Discover.

Please indicate the method of payment you wish to choose:

Cash

Check

Visa or MasterCard

Discover

American Express

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have complete insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance becomes your responsibility. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be cleared in less than 45 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing

For all accounts over 45 days with patient amounts due, there will be a $10.00 billing fee or a finance charge of 1.5% per month, whichever is more. We assign all accounts over 120 days to a collection service for processing.

Should this account become past due, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this amount.

I agree to this financial policy, and I have read and received a copy of this statement.

Patient/Guardian Signature:______________________________ **Date**: ________________

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CANCELLATION POLICY

In order to best serve our patients, we ask that you please make every effort to keep your scheduled appointment. It is your responsibility to know your appointment time. You may or may not receive a courtesy notice 2-days prior by our office staff. If you need to reschedule, please notify us more than 48 hours prior to your appointment time. A charge of $75 will be assessed for any cancellation with less than 48-hour notice. Patients more than 10 minutes late will also be considered as a "NO SHOW".

If you need to cancel an appointment requiring two or more hours (crown, root canal), please notify us at least 7 days prior to your appointment time. A charge of $150 will be assessed for any cancellation with less than 7-day notice for appointments requiring two or more hours. A non-refundable deposit may be collected prior to the appointment.

Patient/Guardian Signature: ______________________ **Date:** ___________