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 Website	☐ 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

☐ Zelle on day of treatment	☐ Credit Card	☐ Debit Card
Signature		Date

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 mysmile.
☐ 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 jawinjury.
☐ I want my teeth straightened	☐ I want my teethwhiter.	

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. Heartdisease	☐ 22. Liver Disease	**Doctor Notes Only:**
☐ 2. Heart Murmur/Mitral Valve Prolapse	☐ 23. Jaundice	
☐ 3. Stroke	☐ 24. Hepatitis Type	
☐ 4. Congenital HeartLesions	☐ 25. Diabetes	
☐ 5. Rheumatic Fever	☐ 26. Excessive Urination and/or Thirst	
☐ 6. Abnormal BloodPressure	☐ 27. Infectious Mononucleosis("Mono")	
☐ 7. Anemia	☐ 28. Herpes	
☐ 8. Prolonged Bleeding Disorder	☐ 29. Arthritis	
☐ 9. Tuberculosis or LungDisease	☐ 30. Sexually Transmitted/Venereal Diseases	☐ 36. AIDS
☐ 10. Asthma	☐ 31. Kidney Disease	☐ 37. Immune SuppressedDisorder
☐ 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 todental treatment.		☐ 44. Are you taking or ever taken Oral Bisphosphonate ForOsteoporosis?
☐ 19. Have you ever taken Fen-Phen or Redux?		
☐ 20. I have had major surgery. Year Type ofoperation		
☐ 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.

Please indicate the method of payment you wish to choose:

☐ Zelle

☐ Visa/Mastercard (3% credit card processing fee will apply)

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 45days.

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 will receive a courtesy notice via text 1 day and 1 hour prior to your appointment. 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 be considered a 'no-show'.

If you need to cancel an appointment requiring two or more hours (root canal/crown), my office requests at least 7 days notice. 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:** _____