# Patient Registration

Today's Date

**Patient Information:**

Patient
First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Patient is: _____ Policyholder
_____ Responsible Party

Address _____

City _____ State/Zip _____ Cell Phone _____

Home Phone _____ Work Phone _____

Email _____

Please circle: Male or Female Marital Status: Married, Single, Divorced, Separated, Widowed

Birth Date _____ Age _____ SS# _____

Employment Status: Full Time Part Time Retired Occupation _____

Student Status: Full Time Part Time Name of School

**Responsible Party (If someone other than the patient)**

First Name _____ Last Name _____ Middle Initial _____

Address _____ Relationship to patient _____

City _____ State/Zip _____ Cell Phone _____

Home Phone _____ Work Phone _____

SS# _____

**Insurance Information**

Name of Policyholder _____

Birthdate of Policyholder _____

SS# of Policyholder _____ ID# _____

Employer or self-Insured _____

Ins. Co. Name _____ Ins. Co. Phone# _____

**Getting To Know You**

How did you hear about our office? _____

Is another member of your family or relative a patient at our office? _____

Person to contact for Emergency? _____

Phone # _____

Address _____

Closest relatative not living with you? _____

Address _____ Phone# _____

City _____ State/Zip _____

Patient Name

Patient Account No.

# DENTAL HISTORY

Medical Alert

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

**What is the reason for your visit today?** _____

_____

**Date of Last Dental Visit** _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

**How often do you have dental examinations?** _____

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

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

**Do you have any dental problems now?** Yes No If yes, please describe: _____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt? | Yes | No |
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught in between your teeth? | Yes | No |

If yes, where _____

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, etc.) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Snore or have any other sleeping disorders? | Yes | No |
| Smoke/chew tobacco or use other tobacco products? | Yes | No |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic treatment? | Yes | No |
| Oral Surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

Please describe, including cause _____

**Have you experienced:**

| | | |
|---|---|---|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |
| **Are you satisfied with your teeth's appearance?** | Yes | No |
| Would you like to replace your silver fillings? | Yes | No |
| Would you like to keep all of your teeth all of your life? | Yes | No |

Do you feel nervous about having dental treatment? Yes No

Please describe _____

Have you ever had an upsetting dental experience? Yes No

Please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

**Is there anything else about having dental treatment that you would like us to know?** Yes No

If yes, please describe _____

_____

Patient Name

Patient Account No.

# MEDICAL HISTORY

Medical Alert

1. Physician's Name _____ Phone (  ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | Ulcers | Yes | No | Hepatitis A B C (circle) | Yes | No |
| Chest Pain | Yes | No | Diabetes | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problems | Yes | No | A.I.D.S./H.I.V. Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| High/Low Blood Pressure | Yes | No | Contact lenses | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chronic Cough | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Asthma | Yes | No | Liver Disease/Yellow Jaundice | Yes | No |
| Cortisone Medicine | Yes | No | Hay Fever/Allergy/Hives | Yes | No | Neurological Disorders | Yes | No |
| Swollen Ankles | Yes | No | Latex Sensitivity | Yes | No | Epilepsy or Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy | Yes | No | Psychiatric/Psychological Care | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Cancer | Yes | No |

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

**History Review**

Dentist Signature _____ Date _____

**SUSAN A.YUNG, D.D.S.**
**JAMES W. JELINEK, D.D.S., P.C.**
**ANDREW Y. JELINEK, D.D.S.**

Patient Name: _____
Date: _____

We know that you are busy and we are always trying to find ways to make our services more convenient for you.

Drs. Yung and Jelinek are committed to providing the highest level of service and as such we have recently implemented a new technology solution that will allow us to send you important, timely messages without interrupting your busy schedule.

This exciting new service gives us the ability to send text messages to the device of your choice (your cell phone, email, or personal digital assistant). Since we send text messages and email messages you don't have to answer a phone call. Simply read it and respond at your earliest convenience. We think this is the best solution for reminding you of your dental appointments and keeping in touch.

Sending reminders to your mobile devices allows us to remind you even when you're not at home. We know that no one wants to miss appointments, but sometimes activities of the day overwhelm us and we forget. With this in mind we are excited to be able to remind you the same day of your appointment, for an afternoon appointment or the day before for a morning appointment. Think of this as a "tap on the shoulder" simply letting you know that we are excited to see you for your appointment.

Please verify and circle your preference of contact below for reminders and confirmations.

Email: Yes / No
If yes, address_____

Text Cell: Yes / No
If Yes, #_____

Phone Call: Yes / No
If Yes, which #: Home_____

Work_____

Cell_____

OR

Postcard for 6 month reminders only: Yes / No

€ Please check the box if you would like us to use the above preferences for other members of your family.
Names: _____

Drs. Yung and Jelinek D.D.S.
60 Rock Pointe Lane
Warrenton, VA 20186
**540-349-0033**
540-347-5872-Fax
yjdentist@gmail.com

# AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office address listed above.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient _____ Print Name _____

Source of Authority _____

**SUSAN A.YUNG, D.D.S.**
**JAMES W. JELINEK, D.D.S., P.C.**
**ANDREW Y. JELINEK, D.D.S.**

# Missed Appointment Policy

Please understand that when we make your appointment, we are reserving time for your particular needs. We ask that if you must change an appointment, please give us at least 24 (business) hours notice. This courtesy makes it possible to give your reserved time to another patient who needs it.

**There will be a $50 charge for missed appointments or appointments that are cancelled within 24 business hours of your appointment.** Repeated cancellations or missed appointments will result in loss of future appointment privileges.

This charge is necessary to defray the cost of reserving the doctor and clinical staff's time. When your appointment is made, the time is reserved and specific preparations are made for you because we feel our patient's time is valuable.

I have read and understand the above statement:

_____ _____

(Patient's Signature) (Date)

**60 ROCK POINTE LANE WARRENTON VIRGINIA 20186 (540)349-0033**

# Financial Agreement

I, the undersigned, hereby agree to pay Drs. Yung & Jelinek DDS all fees due to them for services rendered. Payment will be made at the time of service. I understand that payment of my account is my legal obligation.

The filing of insurance papers and confirmation of insurance coverage for my insurance policy is my responsibility. Any assistance I receive in these matters from the above listed doctor and/or staff is given strictly as a courtesy and implies no responsibility on the part of the doctor and /or staff for confirmation, filing or follow through of insurance matters.

Dental insurance is designed to reduce the cost of dental care. Often, dental insurance is provided as a benefit through an employer or employee groups. The amount of coverage depends solely upon the agreement between the employer/group and the insurance company. Policy benefits are not influenced by this office.

I understand that any amounts not paid by insurance are my responsibility. Insurance companies are required to respond either by letter or payment within 30 days of receiving a claim. Many times insurance companies will request a narrative as a delay tactic or hope that we just don't want to bother and won't do anything. If for any reason we have to submit a narrative or make follow up phone calls to receive payment from your insurance company for a claim, there will be a fee of $ 25.00 for each occurrence. This would not occur until after 30 day period.

Estimates of insurance coverage given to determine my out of pocket amounts are strictly estimates. I understand that I am responsible for any inadequacies in my insurance company's payment. Any insurance claims not paid within 60 days of the date of service become the responsibility of the patient/account holder. All unpaid balances will accrue monthly intrestof 1.5% or 18% per anum.

If this account is placed for collections action, I agree to pay fees of thirty-three and one-third percent of the unpaid principal and interest owing, plus all court costs and interest in the amount of one and one-half percent per month, beginning thirty days after the monies have become due or expenses have been incurred. I further agree to pay returned check charges of $40.00 per returned item.

## Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs. Upon such diagnosis, I authorize doctor 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 possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient/Guardian/Responsible Party _____

Date _____