S Lee Dental Corporation
23571 Lake Drive, P.O.Box 3009, Crestline Ca 92325
(909)338-1782

GET ACQUAINTED QUESTIONNAIRE

Patient Information

Name: Mr. Mrs. Ms. Miss (Please circle one) _____ (Last Name), _____ (First Name) _____ (Middle Name) Birth Date_____
Social Security Number _____ Driver's License Number _____
Residence Address _____ P.O.Box_____
City_____ Zip_____ How long at this address?_____ Phone_____
E-Mail Address_____ Best phone number to call_____ Best time to call_____
Your Occupation _____ Employer_____
Employer's Address _____ City_____ Zip_____
Work Phone _____ ext. _____

Spouse Information or Parent information in case of minor

Name _____ (Last Name), _____ (First Name) _____ (Middle Name) Birth Date_____
Driver's License Number _____ Occupation_____
Employer's Address_____ City_____ Zip _____
Work Phone _____ ext. _____

Dental Insurance Information

Subscriber _____ Insurance Company _____
Subscriber's Date of Birth _____ Subscriber's Social Security Number _____
Insurance Plan _____ Insurance ID _____

Whom may we contact in case of emergency?_____ Relationship _____
Phone Number # 1 _____ Phone Number # 2 _____

How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other_____
If patient referred then who referred you to us?_____

I have read all information and completed the above questions. I certify this information is true and correct to the best of my knowledge.

Signature (Parent if minor)_____ Date_____

ABOUT

DENTAL INSURANCE AND FINANCIAL ARRANGEMENT

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of your dental insurance claim process and our payment policy. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract;
2. Our fees are generally considered to fall within the acceptable range by most companies. Most dental insurance plans do not cover 100% of the cost of your treatment;
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover; and,
4. We must emphasize that as dental care providers, our relationship is with you, not your insurance company.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

GUARANTEE: I (the Patient or Legal Guardian) am an eligible member as of this date of service of the health insurance plan indicated on the front of this form. Signature of responsible party below acknowledges full financial responsibility for services rendered to me and dependent members if it is determined I(dependent) am(is) "Not Eligible" on the date of service in question, or if service rendered is determined to be a non-covered benefit under the insurance plan provisions.

ASSIGNM ENT OF INSURANCE BENEFITS: I hereby irrevocably authorize payment directly to the S Lee Dental Corporation/dentist but not to exceed the S Lee Dental Corporation/dentist's regular charge due as a result of this claim. I understand I am financially responsible to the S Lee Dental Corporation/ dentist for charges not covered.

PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICE: Payments and the insurance deductible for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard orVisa. Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments cancelled without 48 hours advance notice.

To the extent permitted under applicable law, I (patient or legal guardian) authorize release of any information pertinent to my case to insurance company, adjustor, or attorney involved in my case and also authorize insurance payment directly to S Lee Dental Corporation.

Signature of patient or legal guardian _____ Date _____

S Lee Dental Corporation
23571 Lake drive
Crestline, Ca 92325

Patient Name:	Date of Birth:

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1 Yes / No Is your general health good? If NO, explain: _____

2 Yes / No Has there been a change in your health within the last year? If YES, explain: _____

3 Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
If YES, explain: _____

4 Yes / No Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam? _____ Reason for exam: _____
Physician's Name: _____ Phone Number: _____

5 Yes / No Have you had problems with prior dental treatment? If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____

6 Yes / No Are you in pain now? If YES, explain: _____

Blood Pressure: /	Pulse: /mit	Weight: lb

II. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

HEART/BLOOD VESSEL
- Yes / No Rheumatic fever
- Yes / No Heart murmur
- Yes / No Congenital heart defect
- Yes / No Artificial heart valve
- Yes / No Prolapsed heart valve
- Yes / No Heart attack (Date:)
- Yes / No TIA/stroke (Date:)
- Yes / No Coronary heart disease
- Yes / No Congenital heart failure
- Yes / No Angina pectoris
- Yes / No Irregular/rapid heartbeats
- Yes / No Pacemaker
- Yes / No High blood pressure

NERVOUS SYSTEM
- Yes / No Epilepsy/Seizure
- Yes / No Multiple sclerosis
- Yes / No Trigeminal neuralgia
- Yes / No Anxiety/depression
- Yes / No Alzheimer's disease/dementia
- Yes / No Psychiatric treatment
- Yes / No Dizziness/fainting spells
- Yes / No Persistent numbness/tingling

URINARY TRACT
- Yes / No Kidney disease
- Yes / No Venereal disease
- Yes / No Sexually transmitted disease

HEAD & NECK
- Yes / No Glaucoma
- Yes / No Chronic sinusitis
- Yes / No Injury to head, jaw & teeth
- Yes / No Frequent/severe nosebleeds
- Yes / No Sore throat or hoarseness
- Yes / No Difficulty swallowing
- Yes / No Headaches

BLOOD
- Yes / No HIV, AIDS
- Yes / No Blood clots or thrombosis
- Yes / No Anemia
- Yes / No Sickle cell disease/trait
- Yes / No Hemophilia
- Yes / No Transfusion (Date:)
- Yes / No Bruise easily

DIGESTIVE SYSTEM
- Yes / No Hepatitis A
- Yes / No Hepatitis B
- Yes / No Hepatitis C
- Yes / No Cirrhosis of the liver
- Yes / No Frequent heartburn or reflux

ENDOCRINE
- Yes / No Diabetes
- Yes / No Hyper or hypothyroidism
- Yes / No Cushing's syndrome

MUSCULOSKELETAL/CONNECTIVE TISSUE
- Yes / No Sjögren's syndrome
- Yes / No Artificial joint (Date:)
- Yes / No Fibromyalgia/rheumatism
- Yes / No Arthritis
- Yes / No Scarlet fever
- Yes / No Osteoporosis

RESPIRATORY
- Yes / No TB(Tuberculosis)
- Yes / No Asthma
- Yes / No Emphysema
- Yes / No Chronic bronchitis
- Yes / No Shortness of breath
- Yes / No Persistent coughs

CANCER
- Yes / No Cancer
- Yes / No Leukemia
- Yes / No Benign tumors/growths
- Yes / No Radiation/Chemotherapy

ALLERGY
- Yes / No Latex
- Yes / No Penicillin or other antibiotics
- Yes / No Metal/Jewelry
- Yes / No Aspirin
- Yes / No Codeine
- Yes / No Novocaine or Xylocaine

III. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS? (Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Weight loss medications	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin	Yes / No	Over-the-counter medicines

IV. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month?

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

V. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

VI. PLEASE RANK THE FOLLOWING IN THE ORDER IN WHICH THEY WOULD KEEP YOU FROM HAVING DENTAL TREATMENT?

( ) Fear of pain ( ) Cost of treatment ( ) Missing work time ( ) Lack of concern

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

The undersigned hereby authorizes Doctor or his associate to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor or his associate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor or his associate to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) *Date*

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____, acknowledge I have received / read from S Lee Dental Corporation a copy of the Dental Materials Fact Sheet.

_____ _____

Signature of Patient Date

PATIENT ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGMENT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices.
Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.
Our Notice of Privacy Practices is subject to change.
If you have any questions about our Notice of Privacy Practices, please contact Dr. Sean S. Lee at (909)338-1782.

_____ _____

Signature of Patient Date

INABILITY TO OBTAIN PATIENT ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgment, and an attempt to obtain the acknowledgment will be made at the next available opportunity
- ☐ Patient incapacitated/unable to sign
- ☐ Other (Please specify) _____

Patient Name: _____

Signature of Witness: _____ Date/Time: _____