LeeDnF.com

New Jersey
400 Sylvan Ave. 1st Floor
Englewood Cliffs, NJ 07632
T 201-568-8600
happydentalnj@gmail.com

New York
50 Park Ave. Suite 1-G
New York, NY 10016
212 682 6802
drlee38parkavenue@gmail.com

PATIENT INFORMATION

Name:

Date of birth (mm/dd/yy): | SSN: | Driver's Lic. #:

Current address:

City: | State: | ZIP Code:

Home Tel: | Cell: | Email:

Referred by:

MEDICAL / DENTAL HISTORY

Last Physician/Dentist Name:

Physician/Dentist address:

Phone: | E-mail: | Fax:

City: | State: | ZIP Code:

Date of last dental exam (mm/dd/yy): | Date of last physical exam (mm/dd/yy):

CURRENT MEDICAL TREATMENT

Are you currently in good health: Yes No (Please circle)

Are you currently under medical treatment? Yes No (Please circle)

Are you taking medications regularly? Yes No (Please circle)

If "yes," please list medications, dosage, and frequency below:

Have you had any excessive bleeding requiring special treatment? Yes No (Please circle)

Do you ever experience chest pain or excessive shortness of breath with activity? Yes No (Please circle)

Do you have sleep apnea? Yes No (Please circle)

Do you smoke? Yes No (Please circle) | Type: | Frequency:

Have you ever had an allergic reaction to local dental anesthetics or any other dental drugs? Yes No (Please circle)

If "yes," please list allergies below: (including any latex allergy)

Do you use recreational drugs? Yes No (Please circle)

If "yes," please list drugs below:

PLEASE CIRCLE IF YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Heart Attack/Stroke	Heart Murmur	Heart Surgery/ Pacemaker	Mitral Valve Prolepses	Psychiatric Problems
Hemophilia/Abnormal Bleeding	HIV+/AIDS	Liver Problems	Asthma	Arthritis
Drug/Alcohol Abuse	Diabetes	Ulcers/Colitis	Low Blood Pressure	Tuberculosis (TB)
Epilepsy/Seizures/Fainting	Osteoporosis	Hospitalized for any reason	Congenital Heart Defect/Artificial Valve	Severe/Frequent Headaches
High Blood Pressure	Anemia	Blood Transfusion	Hepatitis A B C	Venereal Disease

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Cancer/Chemotherapy/Radiation	Shingles	Rheumatic Fever	Kidney Problems	
Other:				

WOMEN ONLY

Is there a possibility of pregnancy? Yes No (Please circle)

Expected Delivery Date (mm/dd/yy): Trimester?

Are you nursing? Yes No (Please circle)

Are you currently taking birth control pills? Yes No (Please circle)

DENTAL HISTORY
PLEASE CIRCLE ANY CONDITION THAT YOU HAVE NOTICED

Tenderness	Sore Areas	Pain in or near ears	Bleeding gums	Bad breath	Sensitivity to hot/cold
Other:					

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company:

Ins. Co. Address:

City:	State:	Zip Code:
Tel.: ( ) -	Plan Type: PPO HMO (Please circle) Other:	
Group #:	Group Name:	I.D. #:
Subscriber Name:		
Date of birth (mm/dd/yy):	SSN:	Relation to patient:

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the indentifying information form.
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.** You will be responsible for all collection costs, attorneys fees, and court costs. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Dr. Angela Lee , otherwise payable to me.

Signature of patient/parent of patient: Date:

AUTHORIZATION

I authorize Dr. Angela Lee, and her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. **I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.** I have been given the opportunity to ask any question I may have regarding this Notice.

Signature of applicant Date

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PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure occurred prior to the date I revoke this consent is not affected.

Signature of applicant	Date