

Huixin Wang, D.D.S., M.S.
833-G Rockville Pike
Rockville, MD 20852
(301) 279-2501

Patient Information Form

Date _____

Patient Name _____ Preferred Name _____

First Middle Last

Address _____ City _____ State _____ Zip Code _____

Home # _____ Cell # _____ SS# _____

Sex M ___ F ___ Birth Date _____ Email _____

Would you like to be contacted through text? Yes ___ No ___ Email? Yes ___ No ___

Check appropriate box Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Spouse or parent's name _____ Work # _____

Who may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone # _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address (if different from patient's) _____ Home # _____

Driver's License # _____ Birth Date _____ SS# _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Employer _____ Work # _____

Insurance Co. _____ Tel. # _____ Group # _____

Member ID # _____

Ins. Co. address _____

Do you have additional insurance? If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Employer _____ Work # _____

Insurance Co. _____ Tel. # _____ Group # _____

Member ID # _____

Ins. Co. address _____

The information on this form is for our records only and is considered strictly confidential

Medical History

Physician _____ Date of last visit _____

Address _____ Phone # _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Have you had a major operation? _____

Yes No Have you ever had a serious head or neck injury? _____

Yes No Do you take, or have you taken, Phen-Fen or Redux? _____

Yes No Have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes No Are you on a special diet?

Yes No Do you use tobacco?

Female patients only: Are you...

Pregnant? Yes No | Nursing? Yes No | Taking contraceptives? Yes No

If you are you allergic to any of the following, please circle.

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes, please explain _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Recent Weight Loss | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, Parent or Guardian:

_____ Date _____

Dental History

Reason for visit _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed with you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you been told that you grind your teeth? _____

Yes No Do you like the appearance of your smile? _____

Financial Agreement

Thank you for choosing Dr. Huixin Wang D.D.S., M.S. for your dental health needs.

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so we would like to explain our financial options. Please choose the option that works best for you.

1. Payment is due at the time treatment is rendered. We accept cash, American Express, Discover, MasterCard, and Visa.
2. Dental Insurance - As a courtesy to you, we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments, we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you received from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 45 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have have no control over this relationship.

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Minor Patients - The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

Statements - All patients with an outstanding balance will receive a statement each month. All accounts with balances over 90 days will be subjects to our collection agency.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 29% of the debt, and all costs and expense, including reasonable attorney's fees that we incur in such collection efforts.

Returned checks - A fee of \$25.00 will be charged for any returned checks.

I assign directly to Dr. Huixin Wang, D.D.S., M.S. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not my insurance pays for services rendered. I authorize the use of my signature on all insurance submissions. Wintergreen Family Dental practice may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent, I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Dr. Huixin Wang D.D.S., M.S. to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form, please let us know.

Please print patient's full name _____ Date _____

Name of Guardian _____

Signature of patient, parent, or guardian: _____

Patient HIPAA Consent Form

I understand that as part of my healthcare, Huixin Wang, DDS MS originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for my future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- And a tool for routine healthcare options such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to the change, the office will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment., payment or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in action in reliance thereon.

Signed on _____

Print Patient Name _____

Signature _____

Relationship to Patient _____