Jeffrey Lee, M.D., D.M.D.

Patient Information

Patient's Name _____ Age _____ Date of Birth ____ / ____ / ____

(This information is necessary for our files and will be considered CONFIDENTIAL)

If Patient is a minor, give parent's or guardian's information:

Relationship

Residence Address

City State Zip

Residence Phone

Married Single Divorced Separated Widowed

Student Spouse's Name

Driver's License Number

Social Security Number

Employer (or parents employer)

Occupation

Business Address

Business Phone

Spouse's Employer Occupation

Business Address

Business Phone

Name of nearest relative not living with you:

Relationship

Complete Address

Res. Phone

Name of Physician

City Telephone

Name of Dentist

City Telephone

Purpose of Appointment

Is this office visit for Emergency Care?

Whom may we thank for referring you?

Financial Information

Person responsible for this account: Relationship

Address

Street City Zip Phone

Preference of Payment

All deductibles and co-payments are due the day of service.

☐ Cash on day of treatment ☐ State Aid Number ☐ Medical/Dental Insurance

Name of Company

Insurance Group Number Name of Insured Date of Birth

Social Security Number of Insured ☐ Other

Financial Policy

Insurance Coverage

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

1) We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember that paying for your surgical care is your personal responsibility.
2) You will need to pay your portion of the charge as you go. This includes the annual deductible, co-payment, and charges your insurance company refused to pay. Our office policy does not allow us to extend credit.
3) We will need to verify your insurance benefits by contacting the insurance company. We will also have you sign other forms as needed. Please Note: Until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill.
4) We will bill your insurance company the day of your procedure or visit. Payment from your insurance company is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You need to pay us in full at that time. **Bills not paid will be sent to collections.**
5) Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.
6) Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.
7) If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance company will become immediately due and payable by you personally before you leave.

Without Insurance Coverage

The following financial policy applies to all patients who will be paying for their own care. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

You can choose between two different methods of payment.

1. **PAY AS YOU GO** Pay for each individual service before receiving the treatment. You can pay with a check, Master Card , Visa, or American Express.
2. **ARRANGE FINANCING WITH CREDIT COMPANIES** Through a special arrangement with our credit companies (Care Credit and US Med) you may pay for your treatment program with three to six monthly payments with no interest. Ask for the necessary paperwork.

By signing below you agree to follow this policy ☐ Insurance Coverage ☐ Without Insurance Coverage

SIGNED: **X** _____ _____

Patient or Person Financially Responsible for this account. Date

_____ _____

Finance Staff Date

Jeffrey Lee, M.D., D.M.D.

Health History

Date ____ / ____ / ____

Patient's Name _____

Date of Birth _____ / _____ / _____ Social Security Number _____

PLEASE ANSWER ALL QUESTIONS BY CHECKING (3) THE YES or NO BOX. ***All responses are kept confidential.***

Yes	No	
☐	☐	**Are you in good health?**
☐	☐	**Has there been *ANY* change in your general health in the past year?**
		Date of last physical exam? _____
☐	☐	**Are you now under a physician's care for a particular problem?**
☐	☐	**Have you had any serious illnesses, operations, or hospitalizations? If so, describe:**
		_____
☐	☐	**Have you had any adverse effects from medical, surgical, dental treatment?**
☐	☐	**Do you have or have you had:**
☐	☐	Cardiovascular disease:
☐	☐	Rheumatic Fever or Heart disease?
☐	☐	Congenital Heart disease?
☐	☐	Angina / Chest Pain
☐	☐	Heart murmur
☐	☐	Heart trouble
☐	☐	Heart Attack
☐	☐	Coronary Artery disease
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Palpitations
☐	☐	Heart surgery
☐	☐	Pacemaker
☐	☐	Lung disease: Asthma
☐	☐	Emphysema
☐	☐	Chronic cough / Severe coughing
☐	☐	Bronchitis
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Shortness of breath
☐	☐	Liver disease? (jaundice, hepatitis)
☐	☐	Diabetes?
☐	☐	Kidney disease?
☐	☐	Thyroid disease?
☐	☐	Seizures/convulsions/epilepsy?
☐	☐	Fainting spells/ dizziness?
☐	☐	Psychiatric treatment/nervousness/breakdown?
☐	☐	Bleeding disorder/bleeding tendency/bruise easily
☐	☐	Anemia?
☐	☐	Blood transfusion?
☐	☐	Arthritis?
☐	☐	Stomach ulcers or Colitis?
☐	☐	Glaucoma?
☐	☐	Frequent or recurring mouth sores?
☐	☐	Implants placed anywhere in your body (Heart valve, hip, knee)?
☐	☐	Radiation (X-ray) treatment for cancer?
☐	☐	Clicking or popping of jaw joint?
☐	☐	Pain near ear?
☐	☐	Difficulty opening mouth, grind or clench teeth?
☐	☐	Sinus or nasal problems?
☐	☐	Any disease, drugs or transplant operation that has depressed your immune system?
☐	☐	Recurrent infections of any kind?

Yes	No	
		Are you taking or using any of the following:
☐	☐	Thyroid medications?
☐	☐	Antibiotics or sulfa drugs?
☐	☐	Anticoagulants (blood thinners)?
☐	☐	High blood pressure medicine?
☐	☐	Steroids (Cortisone, Etc.)?
☐	☐	Tranquilizers (Valium, Etc.)?
☐	☐	Insulin, Diabenese, or similar drug?
☐	☐	Digitalis, Inderal, Nitroglycerin, Calcium channel blockers, Procardia, or other heart medicine?
☐	☐	Aspirin or Ibuprofen (Motrin, Naprosyn, etc.)?
☐	☐	Marijuana or other street drugs?
☐	☐	Antihistamines or decongestants (Seldane)?
☐	☐	Are you taking Phen-Fen or any other diet drugs?
☐	☐	Are you taking any other regular medications, pills , or drugs? If Yes, please list:
		_____
		Are you allergic or had a bad reaction to:
☐	☐	Local anesthetic (Novocaine, Lidocaine, etc.)
☐	☐	Penicillin, Amoxicillin, Cephalosporins, or other antibiotics?
☐	☐	Barbituates, sedatives, etc.?
☐	☐	Aspirin or ibuprofen?
☐	☐	Codeine or other pain killers?
☐	☐	Latex or other rubber products?
☐	☐	Other allergies or reactions? If yes , please list:
		_____
☐	☐	**Do you smoke or chew tobacco?**
☐	☐	**Do you use alcohol?**

FOR WOMEN ONLY

If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance.

If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant.

☐ ☐ Do you wish to have a pregnancy test?

☐ ☐ **Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?**

☐ ☐ **Do you wish to talk with the doctor privately about anything?**

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

X _____ / _____ / _____

Signature of person completing the health history | Date | Doctor's Initials

Medical Update: I have read my health history dated ____ / ____ / ____ and confirm it adequately states my past and present conditions.

Date	Exceptions or Changes	Patient's Signature	Doctor's initials
Date	Exceptions or Changes	Patient's Signature	Doctor's initials