NATHANIEL J KHOE, DDS, INC.

Cell Phone_______________________________ Home Phone__________________ Date____________________

CHILD INFORMATION

Patient's Name_______________________________________ Prefer to be called_________________ Sex__________

Address____City_________________________Zip_________

Birthday___________________ Age_____ School____________________ Patient resides with ______________________

Please describe your child's orthodontic problem in your own words____

Dentist (full name) ____

Whom may we thank for referring you to our office?____

Children previously treated in our office ____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: Single Married Separated Divorced Widowed

	FATHER	MOTHER
Name	______________________________	______________________________
Address (if different from above)	______________________________	______________________________
Phone (if different from above)	______________________________	______________________________
Social Security Number	______________________________	______________________________
Birthday	______________________________	______________________________
Employer's Name	______________________________	______________________________
Business Address	______________________________	______________________________
Business Phone	______________________________	______________________________
Occupation	______________________________	______________________________
Person Responsible for Account	______________________________	______________________________

If other than parent:

Name __________________________________ Address ______________________________ Phone ________________

Name of Relative in Area ____ Phone ________________

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the PATIENT'S ACCOUNT and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we gladly submit insurance claims pertaining to any charge for care in our office. Initial________

Name of Insured(Employee)_________________________________SS#____________________Date of Birth___________

Name of Insurance Company____Group #_______________

If Dual Coverage

Name of Insured(Employee)_________________________________SS#____________________Date of Birth___________

Name of Insurance Company____Group #_______________

MEDICAL HISTORY

Dr's Name________________________Address__________________________Last Physical_________Phone_______

Have your child experienced any health problems? Yes No Explain___________________________________

Any major change in your child's health recently? Yes No Explain___________________________________

Is your child currently under physician's care? Yes No Explain___________________________________

Is your child currently taking any medication? Yes No List______________________________________

Is your child allergic to any medications? Yes No List______________________________________

Have your child received a blood transfusion? Yes No Reason__________________________________

Have your child's tonsils or adenoids been removed? Yes No When____________________________________

Has your child been in a risk group for AIDS? Yes No Explain___________________________________

Please check if you have had any of the following conditions:

Is there any other condition or problem that you think we should know about your child?___________________________

Heart Murmur................................	Diabetes(type)............................	Cancer ....
Heart problems.............................	Kidney Disease..........................	Bone Disorders ....
Rheumatic Fever...........................	Tuberculosis...............................	Growth Disorders......................
High Blood Pressure.....................	Bronchitis..................................	Mouth Breather.........................
Prolonged Bleeding......................	Asthma	Herpes (Fever Blisters).............
Anemia...	Epilepsy...................................	HIV...
Blood Disease...............................	Fainting	Radiation Treatment.................
Artificial valves/joints....................	Emotional Problems.................	Joint Replacements..................
Hives/Rash..................................	Frequent Headaches................	
Hepatitis (type)............................	Nervous.Anxious	

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DENTAL HISTORY

Previous Dentist Name_____________________________________Address___________________Phone___________

Reason for todays visit?___________________________________Date of last dental visit______________________

Date of last dental X-rays____________________How often do you floss?__________How often do you brush?_______

Bad Breath	Yes	No	Dry mouth	Yes	No	Lip/cheek biting	Yes	No
Bleeding Gums	Yes	No	Food collection between teeth	Yes	No	Loose teeth/broken fillings	Yes	No
Blisters on lips/mouth	Yes	No	Grinding teeth	Yes	No	Mouth breathing	Yes	No
Cigarette/pipe/cigar smoking	Yes	No	Gums swollen	Yes	No	Mouth pain, brushing	Yes	No
Clicking/popping jaw	Yes	No	Jaw pain	Yes	No	Sensitivity to cold/heat/sweets	Yes	No

____ __________________________ ___________________

Parent/Guardian Signature Relationship Date

Date________Medical changes?____Initials______

Date________Medical changes?____Initials______

Date________Medical changes?____Initials______

Date________Medical changes?____Initials______

HIPAA Release of Information for Nathaniel J. Khoe, D.D.S. Inc.

AUTHORIZATION FORM

I, ___________________________________hereby authorize **Nathaniel J. Khoe, D.D.S. Inc.** and its affiliates, employees, and agents to release my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from:

A. From ___/___/______ to ___/___/______
B. All past, present and future periods.

I understand that I have a right to revoke this authorization by providing written notice **Nathaniel J. Khoe, D.D.S. Inc.** However, this authorization may not be revoked if **Nathaniel J. Khoe, D.D.S. Inc.** and its employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient Name: ____ Date: _____/_____/__________

Signature: ____ Relationship: _______________

Patient or Legal Guardian

Patient Photo Release Form for Nathaniel J. Khoe, D.D.S. Inc.

I ______________________________________, hereby authorize Nathaniel J. Khoe, D.D.S. Inc. or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, insurance companies, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial one option:

_____I consent to photographs that are used in any of the above stated situations.

_____I do not consent, which I understand may results in insurances denying claims and will assume responsibilities for any claims denied.

Patient Name: ____ Date: _____/_____/__________

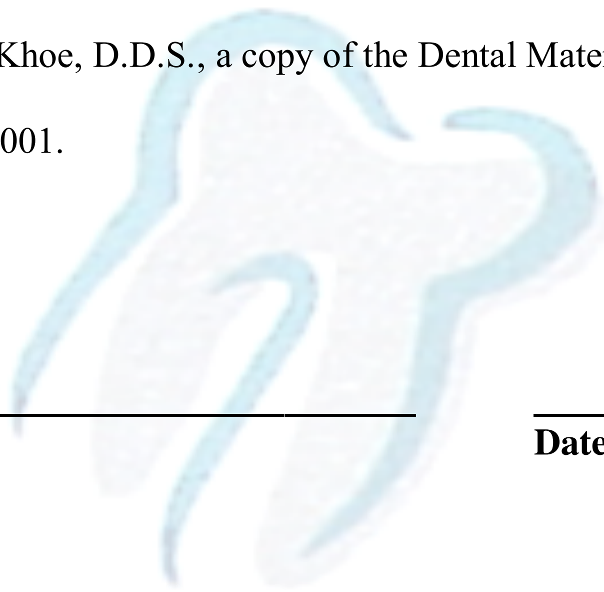
Signature: ____ Relationship: _______________

Patient or Legal Guardian

Nathaniel Khoe D.D.S., INC.
General Dentistry

Patient Acknowledgement of
Receipt of Dental Material Fact Sheet

I, ______________________________, acknowledge I have received from the office of Nathaniel J. Khoe, D.D.S., a copy of the Dental Materials Fact Sheet dated October 2001.



____ ______________
Patient Signature **Date**

For All Visits:

Patients must cancel their appointments within **24 HOURS** in advance for all office visits. Failure to do so, your account will be charged a **$50.00 Cancellation Fee.**

No Exceptions

Thank you for your cooperation!

Patient Name: ____ Date: ____/____/________

Patient Signature: ____

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Nathaniel J Khoe, DDS, INC