NATHANIEL J KHOE, DDS, INC.

Cell Phone_____ Work Phone_____ Home Phone_____ Date_____

ADULT INFORMATION

Patient's Name_____Prefer to be called_____

Address_____City_____Zip_____

Birthday_____SS#_____Driver's License_____ Sex_____

Occupation_____Employer_____

Employer Address_____City_____Zip_____

Referred by_____Do you know a patient in our office? Yes No Whom?_____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name_____Employer_____

Person responsible for account_____ Wk Phone_____

If other than self or spouse

Name_____Phone_____

Name of relative in area_____Phone_____

In case of emergency, who should we notify_____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 you experienced any health problems?	Yes	No	Explain_____
Any major change in your health recently?	Yes	No	Explain_____
Are you currently under physician's care?	Yes	No	Explain_____
Are you currently taking any medication?	Yes	No	List_____
Are you allergic to any medications?	Yes	No	List_____
Have you received a blood transfusion?	Yes	No	Reason_____
Are you pregnant?	Yes	No	What month?_____
Are you taking any diet pills and/or birth control pills?	Yes	No	Explain_____
Are you taking any bone medication? (Bisphosphonate)	Yes	No	List_____
Any problems in sleeping/snoring?	Yes	No	Explain_____
Any premedication REQUIRED before dental treatment?	Yes	No	Explain_____

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

Heart Murmur	Yes	No	Diabetes(type)	Yes	No	Cancer	Yes	No
Heart problems	Yes	No	Kidney Disease	Yes	No	Bone Disorders	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Growth Disorders	Yes	No
High Blood Pressure	Yes	No	Bronchitis	Yes	No	Mouth Breather	Yes	No
Prolonged Bleeding	Yes	No	Asthma	Yes	No	Herpes (Fever Blisters)	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	HIV	Yes	No
Blood Disease	Yes	No	Fainting	Yes	No	Radiation Treatment	Yes	No
Artificial valves/joints	Yes	No	Emotional Problems	Yes	No	Joint Replacements	Yes	No
Hives/Rash	Yes	No	Frequent Headaches	Yes	No			
Hepatitis (type)	Yes	No	Nervous.Anxious	Yes	No			

Is there any other condition or problem that you think we should know about you?_____

_____

_____

DENTAL HISTORY

Previous Dentist Name_____Address_____Phone_____

Reason for todays visit?_____Date of last dental visit_____

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

Date of last dental X-rays_____How often do you floss?_____How often do you brush?_____

Patient's Signature_____Date_____Reviewed by_____

Date_____Medical changes?_____Initials_____

Date_____Medical changes?_____Initials_____

Date_____Medical changes?_____Initials_____

Date_____Medical changes?_____Initials_____

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**

COSMETIC DENTISTRY

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 Cancellation Fee.**

***** No Exceptions*****

Thank you for your cooperation !

Any and all credit or debit transactions are subject to a 2% fee.

Patients Name: _____ Date: __/___/___

Patients Signature: _____

1016 Hutington Dr. Duarte, CA | (626)-305-1320 | KHOEDENTISTRY@GMAIL.COM
Nathaniel J. Khoe DDS Inc.

Nathaniel J. Khoe, D.D.S. Inc.

Insurance Coverage Declaration

Name (please print): _____

Insurance #1 (Primary):_____

Insurance #2 (Secondary): _____

Please select one of the following:

____ I am covered by only one insurance listed. I am not covered by any other health insurance policy through my spouse, parent, guardian or third/other party.

____ In addition to the insurance company listed, I am also covered by another insurance company.

If this applies to you, please indicate the insurance company in the space labeled "Insurance #2" above.

____ In addition to the insurance company listed, I am also covered by another insurance company; however I do not have the insurance information at this time.

It is the patient's responsibility to disclose all medical insurances. Failure to disclose all medical insurances will result in the inability to bill such insurances.

Patient/Guardian Signature: _____ Date: _____

COSMETIC DENTISTRY

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

COSMETIC DENTISTRY

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

1016 HUNTINGTON DRIVE | DUARTE, CA 91010 | (626) 305-1320 | KHOEDENTISTRY@GMAIL.COM
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