ELBERT CHANG, DDS, MS
Rockville Perio, PA • 5830 Hubbard Drive, Rockville, MD 20852 • (301) 881-4867
Practice Limited to Periodontology & Dental Implants

Patient Information

Patient Name: _____ _____ ___ _____
Last First MI Preferred

☐Male ☐Female ☐Married ☐Single ☐Child Birth Date: _____ Age:_____

Contact Info: Phone (Home): _____ (Work): _____ (Mobile): _____

email:_____

Address: _____ _____
Street Apt #

_____ _____ _____
City State Zip Code

Health Information

Reason for today's visit: _____

Referring dentist: _____ Date of last visit: _____

Do you have, or ever had, any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina
- ☐ Anticoagulant (incl aspirin)
- ☐ Arthritis
- ☐ Artificial Joints or Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths or Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease or Jaundice
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phen-Fen
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Smoking/tobacco use/vaping
- ☐ Steroids
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers

☐Other_____

If you have or had any of the above conditions, please explain further (when, what happened, etc)

_____

_____

Please list any medications, drugs, or supplements (or write "none")

_____

_____

_____

Please answer the following questions:

☐ YES ☐ NO Have you had pneumonia in the past 6 to 9 months?

☐ YES ☐ NO Are you pregnant or is there a possibility you may be pregnant?

☐ YES ☐ NO Have you ever had periodontal treatment in the past? If yes, which of the following:

- ☐ Scaling and root planning (deep cleaning)
- ☐ Periodontal surgery (including implants)
- ☐ Other dental surgery

☐ YES ☐ NO Do you grind your teeth?

☐ YES ☐ NO Do you your jaw or joints ever click, pop, or give you pain?

☐ YES ☐ NO Do you have a night guard?

☐ YES ☐ NO Do you have any allergies? If yes, please list _____

_____

☐ YES ☐ NO Have you ever been hospitalized or had a major operation?

If yes, please list the reason and when:_____

_____

☐ YES ☐ NO Are you now under the care of a physician (family doctor)?

When was your last physical? _____

Name of Physician: _____Phone: _____

☐ YES ☐ NO Have you ever had any complications following dental treatment?

☐ YES ☐ NO Do you have any concerns that you would like to discuss with the doctor privately?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will promptly inform the doctor at the next appointment.

_____ _____

Name of patient, parent or guardian Date

☐ By checking this box, your electronic signature will be applied to this form and will have the same legal effect as a handwritten signature

Insured or Responsible Party Information

The following is for (check all that apply): ☐ the Insurance Subscriber ☐ self ☐ the patient's spouse/parent

Name: _____ Employer: _____

Birth Date: _____ Insurance Carrier: _____ Ins ID#_____

Phone (Home): _____ (Work): _____ email:_____

Address: _____ _____
Street Apt #

_____ _____ _____
City State Zip Code

Notice of Privacy Practices

Our Legal Duty:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice take effect March 1, 2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

Please inform us if you require more information regarding our Privacy Practices.

Uses and Disclosure of Health Information:

- •Treatment
- •Payment
- •Healthcare Operations
- •Your Authorization
- •To Your Family and Friends
- •Persons Involved In Your Care
- •Abuse or Neglect
- •Required by Law
- •National Security
- •Appointment Reminders

Acknowledgement to Receipt of Office Privacy Policy

I have reviewed this Notice of Privacy Practices.

_____ _____ _____
Name of patient, parent or guardian Date Relationship to Patient

☐ By checking this box, your electronic signature will be applied to this form and will have the same legal effect as a handwritten signature

Consent for Services

I hereby give consent for the doctor and staff to perform such diagnostic, photographic, and therapeutic procedures as may be necessary on myself or my child. As a condition of treatment by this office, payment is due at the time of service. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that the charges will be paid by an insurance company.

Missed appointments will be charged at the rate of a normal office visit, unless cancelled 48 hours in advance.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A fee of 35% of the account balance will be added to account that are referred to a collection agency in addition to court costs and attorneys' fees.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder. A copy of this form will be provided upon request.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Name of patient, parent or guardian Date Relationship to Patient

☐ By checking this box, your electronic signature will be applied to this form and will have the same legal effect as a handwritten signature

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies please do not hesitate to ask one of our staff members.

Payments for services rendered are due at time of treatment. We accept cash, personal checks, Visa, MasterCard, and Discover. We will help you process your insurance claim for your reimbursement as long as we have all of your insurance information. Y**ou will be required to pay the portion of the service that we estimate will not be paid by the insurance company.**

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract (with the exception of some dental PPO insurances). Our financial relationship is with you, not your insurance company.

2. **All charges are your responsibility, whether or not your insurance company pays.** Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments, are due at time of treatment. **We will collect the expected patient portion at the time of service.**

4. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion.

5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance in full with cash, personal check, Visa, MasterCard, or Discover.

6. Balance older than 30 days will be subject to interest charges of 1.5% per month. Returned checks will have additional fee of $40.00 added to the amount of the returned check.

7. If it becomes necessary, at our discretion, to turn an overdue balance over to collection, you will be responsible for costs of collection, in addition to court costs and attorney's fees actually incurred in the collection of your account. We may also report to credit bureaus.

8. If a statement has been sent and the account is not paid prior to the next billing cycle, at $100.00 rebilling fee will be charged.

Cancellations: Please note that, unless we are notified at least two business days in advance, you will be charged $75.00 for a cancelled visit. For Monday appointments, we request notification prior to the close of business on Thursday. Please call the office as soon as possible if you have to reschedule. Cancellations affect many people including you (your dental health), the doctor and staff, and the patient(s) who could have been scheduled; they also increase the cost of care. _____(Initials)

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing our office as your dental care provider. We appreciate your confidence and the opportunity to serve you.

NAME (print) _____ DATE _____

☐ By checking this box, your electronic signature will be applied to this form and will have the same legal effect as a handwritten signature

Patient Screening Form

Name:

	PRE-APPOINTMENT	IN-OFFICE
For you and your household, please answer the following:	Date:	Date:
...have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
...have shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
...have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
...have an other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
...have experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
...in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
...have traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Is the patient over the age of 60 years?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.