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***Welcome to the office of Dr. Steven Go dba OC Dental Arts Patient Info (Confidential and HIPAA Compliant)***

First Name MI Last Name Birth date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Cell Phone E-mail

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security (Confidential) Drivers License

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one : Single/ Married/ Divorced/ Widowed/ Separated

Employer or School (If Full Time Student) City State Zip Phone number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (If different than patient)**

First Name MI Last Name Relationship Birth Date Social Security #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Phone number Alt Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information**

Name of Insured Insurance company Birth Date Employer

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number Group or Policy # Insurance Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information (**if applicable**)**

Name of Insured Employer Birthdate Social Security # Group #

**Patient Medical History** (may we discuss your Medical History with your physician?) Yes No

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Allergic to or have had any reactions to the following?

 Yes No Yes No

Local Anesthetics \_\_\_\_ \_\_\_\_ Are you under medical treatment? \_\_\_\_ \_\_\_\_\_

Penicillin \_\_\_\_ \_\_\_\_ Any surgeries within the last 3 months \_\_\_\_ \_\_\_\_\_ Sulfa Drugs \_\_\_\_ \_\_\_\_ Do you use tobacco? \_\_\_\_ \_\_\_\_\_ Aspirin \_\_\_\_ \_\_\_\_ If you are taking any current medications. Please list

Any metals \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex Gloves \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only Yes No

* Are you pregnant or think that you may be pregnant \_\_\_\_\_ \_\_\_\_\_
* Are you nursing \_\_\_\_\_ \_\_\_\_\_
* Are you taking any oral contraceptives \_\_\_\_\_ \_\_\_\_\_

Do you or have you had any of the following?

 Yes No Yes No Yes No

High Blood Pressure \_\_\_ \_\_\_ Heart Disease \_\_\_ \_\_\_ Chest Pain \_\_\_ \_\_\_

Heart Attack \_\_\_ \_\_\_ Cardiac Pacemaker \_\_\_ \_\_\_ Stroke \_\_\_ \_\_\_

Rheumatic Fever \_\_\_ \_\_\_ Heart Murmur \_\_\_ \_\_\_ Tuberculosis \_\_\_ \_\_\_

Fainting/Seizures \_\_\_ \_\_\_ Anemia \_\_\_ \_\_\_ Radiation Therapy \_\_\_ \_\_\_

Asthma \_\_\_ \_\_\_ Emphysema \_\_\_ \_\_\_ Glaucoma \_\_\_ \_\_\_

Low Blood Pressure \_\_\_ \_\_\_ Cancer \_\_\_ \_\_\_ Liver Disease \_\_\_ \_\_\_

Epilepsy/Convulsion \_\_\_ \_\_\_ Arthritis \_\_\_ \_\_\_ Respiratory Problems \_\_\_ \_\_\_

Leukemia \_\_\_ \_\_\_ Joint Replacement \_\_\_ \_\_\_ Mitral Valve Prolapse \_\_\_ \_\_\_

Diabetes \_\_\_ \_\_\_ Joint Implant \_\_\_ \_\_\_ Bleeding Disorder \_\_\_ \_\_\_

Kidney Disease \_\_\_ \_\_\_ Hepatitis/Jaundice \_\_\_ \_\_\_ Stomach Troubles \_\_\_ \_\_\_

AIDS or HIV \_\_\_ \_\_\_ STD \_\_\_ \_\_\_ Fosomax (Bisphosphonates) \_\_\_ \_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Dental History

Name of previous Dentist and Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No

Do you feel pain in any of your teeth? \_\_\_\_\_ \_\_\_\_\_

If yes, which area\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any head or neck injuries? \_\_\_\_ \_\_\_\_

Do you have frequent headaches? \_\_\_\_ \_\_\_\_

Do you have any jaw problems or TMJ related issues? \_\_\_\_ \_\_\_\_

Would you like your smile improved? \_\_\_\_ \_\_\_\_

**Authorization and Release**

The above questions have accurately answered and I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Steven Go to perform a diagnostic and necessary exam, x-rays, photographs and/ or models. With my consent, I authorize Dr. Steven Go to perform necessary dental procedures with or without anesthetic, pre-medication and/or sedation, which his judgment may indicate during treatment.

Patient signature (or parent if minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_



**OFFICE POLICY**

We want to thank you for allowing our office the opportunity to participate in your oral health. We take great pride in our office and feel that it is our mission to render the finest services to our patients. In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that anytime you have a question or concern with your treatment, fees for service or attitude of our staff, that you will discuss it promptly and openly. Misunderstandings and lack of communication are the only obstacles to our continued professional relationship.

If you are unable to keep a schedule appointment, we ask that you kindly provide us with at least 24- hour notice, to avoid a $25 cancelation fee. This courtesy on your part will make it possible to give your appointment to another patient.

**FINANCIAL POLICY**

We respectfully request payment be made on the date of service. Forms of payment include check, cash, or credit card. Fees are subject to change with prior notice before treatment. There is a $25 processing fee for returned checks. For our patients with the benefits of insurance coverage your estimated patient portion is due on the date of service. The estimated insurance portion is not a guarantee of payment. It is the patient’s responsibility to understand their insurance policy prior to treatment. As a courtesy to you, our office will complete and submit insurance forms to services rendered to our insurance company. Your insurance is a contract between you and them, we only act to help with billing, and the premiums, maximums and covered service are outlined by the insurance, not our office. In the event, that your insurance does not pay the whole or in part for any reason, you will be responsible for the remaining balance.

I take responsibility for payment on all services rendered on my behalf, my dependent involved in dental insurance.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION RELEASE**

I hereby authorize my insurance company to pay Dr. Steven Go the benefits accruing to me under my dental/medical insurance policy for services rendered. I understand I am financially responsible for charges not covered by this assignment. I hereby authorize my doctor to release any and all information to my dental/medical insurance which may be requested regarding my treatment.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of Dr. Steven Go, DDS Inc. notice of privacy practice

Please print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is someone you would like us to discuss your health financial, or personal information with, please list them below:

Please review and circle the best way for you to be contacted

By Phone: Yes / No Can a detailed message be left on voicemail? Yes / No

By Test: Yes / No By Email: Yes / No

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our notice of privacy practice but could not be obtained because

INDIVIDUAL REFUSED TO SIGN

COMMUNICATION BARRIER

AN EMERGENCY SITUATION PREVENTED US

OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_