MEMORIAL HEIGHTS DENTAL CENTER

Dr. C. Tim Hung, D.D.S.
920 Studemont St. Suite 500 | Houston, TX 77007
(713) 869-0600

Welcome!

Welcome to Memorial Heights Dental Center! Please fill out the form below (starred entries are required) and bring all your completed forms to the front desk with your **driver's license** and **insurance card**.

Date: _____/_____ /_____ Appointment Time: _____

PERSONAL INFORMATION

***Date of Birth: _____/_____ /_____ Dr. /Mr. /Mrs. /Ms./ Miss (Please circle)**

***Last Name: _____ *First Name: _____ MI:_____**

□ **Single**
□ **Married**
□ **Child**
□ **Dependent**

***Responsible Party: _____**

Address: _____

***Address: _____ *City: _____ *State: _____ *Zip code:_____**

***Home Phone: (_____) _____ Cell Phone: (_____) _____ Business Phone: (_____) _____**

E-mail:_____ *Employer: _____ Position: _____

***Social Security: _____/_____ /_____ *Driver's License:_____**

CONTACT INFROMATION

***Emergency Contact: _____ *Phone: (_____) _____ *Relationship:_____**

Spouse: _____ Spouse's Phone: (_____) _____

Spouse's Employer: _____ Position: _____

***Your Primary Physician: _____ *Office Phone: (_____) _____**

***Referred by: Patient: _____ Internet: _____ Other: _____**

INSURANCE INFORMATION

***Dental Insurance? □ Yes □No *Insurance Company Name: _____**

***Address: _____ *Phone: _____ *Employer: _____**

***Group Number: _____ *ID Number: _____**

***Insured Name: _____ *Social Security: _____/_____/_____**

***Insured's Date of Birth: _____/_____ /_____ *Relationship to patient: _____**

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Dental & Medical History

DENTAL HISTORY

1.	Date of last dental visit: _____			
2.	Are you sensitive to (*check all that apply*) :	□**Heat**	□ **Cold**	□**Sweets**
3.	Do you (*check all that apply*):	□**Grind your teeth**		□**Wear a night guard**
4.	Do you have (*check all that apply*):	□**Clicking**	□**Popping**	□**Pain in Jaw Joints**
5.	Do your gums bleed?	□**Yes**		□**No**
6.	Are you experiencing pain in your mouth at this time?	□**Yes**		□**No**
7.	Have you noticed any loose or shifting teeth?	□**Yes**		□**No**
8.	Have you experienced bad breath/ bad taste in your mouth?	□**Yes**		□**No**
9.	Have you worn braces or Invisalign?	□**Yes**		□**No**
10.	Would you be interested in dental implants?	□**Yes**		□**No**

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, it is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interaction with the dental care you will receive. Please answer the following questions as accurately as you can.

1.	Are you under a physician's care now?	□**Yes**	□**No**	**If yes, please explain:** _____
2.	Have you ever been hospitalized or had a major operation?	□**Yes**	□**No**	**If yes, please explain:** _____
3.	Have you ever had a serious head or neck injury?	□**Yes**	□**No**	**If yes, please explain:** _____
4.	Are you taking any medications, pills, or drugs?	□**Yes**	□**No**	**If yes, please explain:** _____
5.	Do you take, or have you taken, Phen-Fen or Redux?	□**Yes**	□**No**	_____
6.	Are you on a special diet?	□**Yes**	□**No**	_____
7.	Do you use tobacco?	□**Yes**	□**No**	
8.	Do you use controlled substances?	□**Yes**	□**No**	

Women (*check all that apply*):
□Pregnant/Trying to get pregnant □Taking oral contraceptives □Nursing

Allergies (*check all that apply*):
□Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex □Local Anesthetics
□Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	□Yes □No	**Cortisone Medicine**	□Yes □No	**Hemophilia**	□Yes □No	**Renal Dialysis**	□Yes □No
Alzheimer's Disease	□Yes □No	**Diabetes**	□Yes □No	**Hepatitis A**	□Yes □No	**Rheumatic Fever**	□Yes □No
Anaphylaxis	□Yes □No	**Drug Addiction**	□Yes □No	**Hepatitis B or C**	□Yes □No	**Rheumatism**	□Yes □No
Anemia	□Yes □No	**Easily Winded**	□Yes □No	**Herpes**	□Yes □No	**Scarlet Fever**	□Yes □No
Angina	□Yes □No	**Emphysema**	□Yes □No	**High Blood Pressure**	□Yes □No	**Shingles**	□Yes □No
Arthritis/Gout	□Yes □No	**Epilepsy or Seizures**	□Yes □No	**Hives or Rash**	□Yes □No	**Sickle Cell Disease**	□Yes □No
Artificial Heart Valve	□Yes □No	**Excessive Bleeding**	□Yes □No	**Hypoglycemia**	□Yes □No	**Sinus Trouble**	□Yes □No
Artificial Joint	□Yes □No	**Excessive Thirst**	□Yes □No	**Irregular Heartbeat**	□Yes □No	**Spina Bifida**	□Yes □No
Asthma	□Yes □No	**Fainting Spells/Dizziness**	□Yes □No	**Kidney Problems**	□Yes □No	**Stomach/Intestinal**	□Yes □No
Blood Disease	□Yes □No	**Frequent Cough**	□Yes □No	**Leukemia**	□Yes □No	**Stroke**	□Yes □No
Blood Transfusion	□Yes □No	**Frequent Diarrhea**	□Yes □No	**Liver Disease**	□Yes □No	**Swelling of Limbs**	□Yes □No
Breathing Problem	□Yes □No	**Frequent Headaches**	□Yes □No	**Low Blood Pressure**	□Yes □No	**Thyroid Disease**	□Yes □No
Bruise Easily	□Yes □No	**Genital Herpes**	□Yes □No	**Lung Disease**	□Yes □No	**Tonsillitis**	□Yes □No
Cancer	□Yes □No	**Glaucoma**	□Yes □No	**Mitral Valve Prolapse**	□Yes □No	**Tuberculosis**	□Yes □No
Chemotherapy	□Yes □No	**Hay Fever**	□Yes □No	**Pain in Jaw Joints**	□Yes □No	**Tumors or Growths**	□Yes □No
Chest Pains	□Yes □No	**Heart Attack/Failure**	□Yes □No	**Parathyroid Disease**	□Yes □No	**Ulcers**	□Yes □No
Cold Sores/Fever Blisters	□Yes □No	**Heart Murmur**	□Yes □No	**Psychiatric Care**	□Yes □No	**Venereal Disease**	□Yes □No
Congenital Heart Disease	□Yes □No	**Heart Pace Maker**	□Yes □No	**Radiation Treatments**	□Yes □No	**Yellow Jaundice**	□Yes □No
Convulsions	□Yes □No	**Heart Trouble/Disease**	□Yes □No	**Recent Weight Loss**	□Yes □No		

Have you had any serious illness not listed above? □Yes □No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform Memorial Heights Dental Center of any changes in my medical status.

_____ _____
Signature of Patient, Parent, or Guardian Date

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Financial Policy

Thank you for choosing Memorial Heights Dental Center! At our office, we work hard to provide you with affordable dental care that meets your needs. Your prompt payment will allows us to deliver high-quality treatment in an efficient and thorough way. Therefore, we ask all our patients to pay in full at the time the services are provided unless prior payment arrangements have been made.

Payment options include:

- **Cash** or **Check**
  - Returned checks are subject to a $35 fee.
  - The full balance and the fee must be paid within 10 days using another method of payment.
- **Visa**, **MasterCard**, **American Express**, or **Discover Card**
- **CareCredit** (for treatments of $1,000 or more)
  - Allows you to pay over time with NO INTEREST*
  - Convenient, low monthly payments are also available
  - No annual fees or pre-payment penalties

Insurance:
For patients with dental insurance, we will work with your insurance company to maximize your benefits. As a courtesy, our office will directly bill your provider for reimbursements. If we do not receive full payment from your insurance company, you will be responsible for paying the remaining balance and collecting any benefits directly from your provider. **Ultimately, you are responsible for your account.**

Your policy is a contract between you and your insurance company. Please do not contact our office regarding your benefits or coverage. It is your responsibility to provide us with your accurate insurance and billing information. Complete dental insurance information must also be presented at the first visit. Your estimated co-payment is due at the time services are provided.

Other Notes:

- If you choose to discontinue care before treatment is completed, a refund will be determined based upon a review of your case.
- For treatment plans of **$500 or more**, a **10% deposit** is required to secure your initial treatment appointment.
- Account balances **60 DAYS PAST DUE** will be charged **1.5% INTEREST PER MONTH**. Your prompt payments are greatly appreciated.
- Treatment estimates will remain ***valid for 90 days***. We do our best to provide accurate estimates as long as treatment is performed in a timely way. Please note that insurance estimates are not a guarantee of payment, and you will be responsible for your treatment fees. Also be aware that we treat you based on your dental health needs, not upon what your insurance policy will cover. Therefore, we may recommend some non-covered treatments.
- A **cancellation/no show fee of $45** will be charged to patients who miss their appointments without notifying us at least **1 business day in advance**. See our *Broken Appointment Policy* for more details.

We are happy to discuss any financial concerns with you and assist you in managing your account. Please contact us if you have any questions.

Please sign below to indicate that you have read, understand and accept Memorial Heights Dental Center's financial policy.

_____ _____
Patient, Parent or Guardian Signature Date

_____
Patient Name

*Subject to a one-time transaction fee

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Consent for Use & Disclosure of Health Information

Please read the following statements carefully and initial next to each one to indicate that you understand and give your consent.
If you choose to revoke your consent, fill out the form at the bottom. You are entitled to a copy of this form after you sign it.

*_____ **Notice of Privacy Policy**: I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations by Memorial Heights Dental Center/Dr. C. Tim Hung.

You have the right to read our Notice of Privacy Practices (ask us for a copy) before you decide whether to sign this consent form. Our notice provides information regarding our treatment, payment activities, and healthcare operations, how we may use or disclosure your protected healthcare information, and other important matters about your protected health information. We also reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

*_____ **Photographic Consent & Waiver**: I consent to the use of my dental photographs/x-rays taken by Memorial Heights Dental Center/Dr. C. Tim Hung in official medical publications or in print or video formats in connection with articles, lectures, or broadcasts for research purposes.

*_____ **Right to Revoke**: I understand that I will have the right to revoke this consent at any time by giving written notice of my revocation submitted to Memorial Heights Dental Center/Dr. C. Tim Hung. I understand that revocation of this consent will not affect any action Memorial Heights Dental Center took in reliance of this consent before they received my revocation and that they may decline to treat me or continue treating me if I revoke this consent.

I, *_____, have read and considered the contents of this consent form and the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

*_____ *_____
Signature Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

_____

Relationship to the Patient:

_____

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Smile Evaluation:

This is a simple questionnaire to help you obtain the smile you've always wanted. Hold a full face mirror 12-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully as you answer the following questions.

1. Do you like the appearance of your teeth and smile? ___ Yes ___ No

If not, explain_____

2. Are your teeth all in alignment (straight)? ___ Yes ___ No

If not, explain_____

3. Do you have spaces that you don't like? ___ Yes ___ No

If not, explain_____

4. Do you like the color of your teeth? ___ Yes ___ No

If not, explain_____

5. Do you like the shape of your teeth? ___ Yes ___ No

If not, explain_____

6. Are your teeth ___ Chipped ___ Protruding ___ Hidden?

7. Do you like the way your teeth come together? ___ Yes ___ No

If not, explain_____

8 Are there old fillings or dental work that you don't like looking at? ___ Yes ___ No

If not, explain_____

9. What would you like to change most in the appearance of your smile?

_____

_____

10. How would you like your smile to look?

_____

_____