CHUNG HIN LAU,DDS
REGISTRATION FORM

Today's date:	

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Apt#	Social Security no.: - -	Home phone # ( ) -

City:	State:	Zip Code:	Work phone # ( ) -

Occupation:	Employer:	Cell phone # ( ) -

Referred to office by:		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work		❑ Email Address

Other family members treated here:

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone # (if different): ( ) -

Is this person a patient here? ❑ Yes ❑ No

Employer:	Employer address:	Work phone # (if different) ( ) -

Is this patient covered by insurance? ❑ Yes ❑ No

Name of the insurance	

Insured name:	Insured S.S. # - -	Birth date: / /	Group #	Insurance ID	Co-payment: $

Patient's relationship to Insured:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Insured name:	Group #	Policy #

Patient's relationship to Insured:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Lau. I understand that I am financially responsible for any balance. I also authorize Chung Hin Lau, DDS or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CHUNG HIN LAU,DDS
REGISTRATION FORM

(Please Print)

Today's date:	

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation
Are you in pain? ❑ No ❑ Yes How long? ____
Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen, or bleeding gums. ❑ Teeth grinding ❑ Locking jaw
❑ Sensitive tooth, teeth, or gums. ❑ Ringing in ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth
❑ Other: ____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know
Previous Dentist: ________________________________ Ph# (____) _________________________________
Last Dental exam: ___/___/______ Last Dental X-Rays: ___/___/_____
Times a day you brush? _________ Times a week you floss? ________
What type of toothbrush do you use? ❑ Soft ❑ Medium ❑ Hard
How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑Muscle Relaxers
❑ Stimulants ❑ Blood Thinners ❑Tranquilizers ❑ Insulin ❑Meds for Osteoporosis
❑ Other(s), please list: ____

Do you have or have you had any of the following diseases, medical conditions or procedure?

Y N Heart Attack/ Stroke	**Y N** Thyroid Problems	**Y N** Cancer/ Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./ Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headache	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ____________________________________
____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑Tetracycline ❑Aspirin
❑ Dental Anesthetics ❑ Foods: ________________________________ ❑ Others: ____________
Do you use tobacco? ❑ No ❑ Yes/ How used? ______________ How much? ______ How long? ______
Please rate your general health from 1-10: __________________ Do you wear contact lenses? ❑ Yes ❑ No
For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? __________
Are you pregnant? ❑ No ❑ Yes/ How long? __________________ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ Date ____/____/_____
❑ Adult Patient ❑Parent or Guardian ❑Spouse

CHUNG HIN LAU,DDS
CONSENT INFORMATION

CONSENT TO TREAT:

▪This information I have provided Dr. Chung Hin Lau's office is complete and true to the best of my knowledge.
▪I authorize the doctors and staff of Chung Hin Lau, DDS., PLLC, to administer such procedures and treatment as they deem necessary.

PATIENT OR LEGAL GUARDIAN SIGNATURE:_______________________________________ DATE:___________

CONSENT TO TREAT A MINOR CHILD:

▪ The information I have provided this office pertaining to ____ is true and complete to the best of my knowledge.
▪ I authorize the doctors and staff of Chung Hin Lau, DDS, PLLC, to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody.

PATIENT OR LEGAL GUARDIAN SIGNATURE:_____________________________ DATE:________

FOR WOMEN ONLY:

▪ The doctor or a staff member of Chung Hin Lau, DDS has advised me that x-rays can be hazardous to an unborn child.
▪ At this time and to the best of my knowledge, I am NOT pregnant. I consent to having x-rays taken.

PATIENT OR LEGAL GUARDIAN SIGNATURE:_____________________________ DATE:________

CHUNG HIN LAU,DDS
FINANCIAL POLICY

PATIENTS PAYING PRIVATELY:

▪I understand that payment is due the day the dental services are rendered.
▪If I am under going treatment that will consist of a few visits, I understand that payment is due by the final visit of treatment unless other financial arrangements have been made.

PATIENT OR LEGAL GUARDIAN SIGNATURE:____________________________ DATE:________

INSURANCE PATIENTS (PARTICIPATING AND NON-PARTICIPATING):

PARTICIPATING:

▪I authorize release of any dental or other information which is necessary to process any claims that are submitted on my behalf.
▪I understand that Chung Hin Lau, D.D.S. has agreed to bill my participating insurance company for the treatments performed and that I am financially responsible for **ANY** and **ALL** amounts not otherwise paid by my insurance carrier including but not limited to yearly deductibles, coinsurances, non-covered services, and if my yearly maximum has been reached.
▪I also agree to forward immediately any insurance payments that I receive for these services.
▪I request that payment of authorized insurance benefits be made on my behalf to Chung Hin Lau, D.D.S.

PATIENT OR LEGAL GUARDIAN SIGNATURE:____________________________ DATE:________

NON-PARTICIPATING:

▪I authorize release of any dental or other information which is necessary to process any claims that are submitted on my behalf.
▪I understand that I am responsible for the difference between Dr. Chung Hin Lau's fees and my insurance company's allowable amount because the office is NOT participating with my insurance company. I will pay for services rendered and the office will submit a dental claim for my reimbursement.

PATIENT OR LEGAL GUARDIAN SIGNATURE:____________________________ DATE:________

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO **AN ADDITIONAL $15.00 PROCESSING FEE EACH MONTH** IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

Chung Hin Lau, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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