Edward Moon D.D.S.

Oso Parkway suite 290 Mission Viejo, CA 92691

Personalized Care you can trust

Patient Registration

Name: _____ Date of Birth: _____

Responsible Party (if the above patient is a minor):_____

Address: _____ Social Sec#: _____

City/State/Zip: _____ Home Phone: _____

Email: _____ Marital Status: _____ Cell Phone: _____

Employer: _____ Occupation: _____

May we contact you via: Home Phone (Yes/No), Cell Phone (Yes/No), Text (Yes/No), Email (Yes/No)

Whom may we thank for referring you to our office? Or, how did you hear about us? _____

Emergency Contact Name & Phone #: _____

Insurance Information

Policy Holders Name: _____ Date of Birth: _____
(If different than above)
Insurance Co. _____ SS/ID#: _____

Claims Address: _____ Group#: _____

Dental History

Reason for today's visit: _____ Date of last dental care: _____

Former Dentist name & phone #: _____

If there is anything you can change about your smile, it would be:_____

Authorization

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Edward Moon D.D.S. all insurance benefits, if any otherwise payable to me for services rendered. I also authorize the use of my signature on all insurance submissions.

I consent and authorize Edward Moon D.D.S. to take face, profile, head/neck &/or inside the mouth photographs, video or any other image that may be necessary of me/my child, with or without given name or with a fictitious name, for treatment, education, social media, and any other lawful healthcare purpose. I release and forever discharge these phots from any claim of ownership, demands or liability on account for such use and acknowledge they are the exclusive property and copyright of Edward Moon D.D.S.

Print name:_____ Signature:_____ Date:_____

Medial History

Circle all that apply:

Heart Disease/Attack	Yes	No
Heart Murmur	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Pacemaker	Yes	No
Stroke	Yes	No
PRE-MEDICATION required	Yes	No

Asthma	Yes	No
Sinus Problems	Yes	No
Seasonal Allergies	Yes	No
Mouth Breather	Yes	No
Snoring	Yes	No
Sleep Apnea	Yes	No

If yes, do you wear CPAP?_____

Periodontal (gum) disease & dental infections may increase your risk for heart attack, stroke, and other cardiac concerns.

Anemia	Yes	No
Bleeding Disorders	Yes	No
Blood Thinners	Yes	No
Hepatitis	Yes	No
Type I/II Diabetes	Yes	No

Studies have a strong correlation between diabetes and Periodontal disease.

History or current use of		
Tobacco	Yes	No
Recreational drugs	Yes	No
History of Braces	Yes	No
For Women:		
Currently Pregnant	Yes	No
Currently Nursing	Yes	No

Pregnant women with Periodontal disease may have up to 7 times Increased risk for Pre-term birth weight baby.

Cancer	Yes	No
Radiation/Chemo	Yes	No
Artificial Joints	Yes	No
Seizures	Yes	No
AIDS/HIV	Yes	No
HPV	Yes	No
Headaches	Yes	No
Dizziness	Yes	No
Jaw Clicking/Popping	Yes	No
Limited Opening Jaw	Yes	No
Clenching/Grinding	Yes	No
Difficulty Swallowing	Yes	No
Bleeding Gums	Yes	No
Dry Mouth	Yes	No

Sensitivity to: Hot ( ) Cold ( ) Sweets ( ) While Biting ( )

How often do you brush? _____

How often do you Floss? _____

Allergies to Medication(s), latex, or any substance?_____

List all the medication(s) you are currently taking. _____

List any health concerns not listed above: _____

Do you have any dental fears? Yes No If yes, Please explain_____
(Noise? Injection? Etc.)

Consent

I undersigned hereby authorize doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my needs. (initial_____)

I authorize doctor to perform all recommended treatments mutually agreed upon and to use appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. (initial_____)

Print name:_____ Signature: _____ Date:_____

Edward Moon D.D.S. 26932 Oso Parkway suite 290 Mission Viejo, CA 92691 949-348-1212

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Financial Policy

Patient's name: _____

I understand that my insurance, if any, is an agreement between myself and my insurance company. I am aware that I will be responsible for my insurance coverage, frequency limitations, maximums, and deductibles. I also understand that I will be responsible for all remaining balances regardless of my insurance coverage and benefits (initial_____)

I understand that there will be a $25 charge for returned checks and a **18%** interest finance charge if the balance is past due beyond 30 days. (initial_____)

Cancellation Policy

We enforce a very strict cancellation policy. The reason for this is because we do not double book our patient's appointments. The time we reserve for you is fully dedicated to care for you only. **So if you must cancel or reschedule an appointment, please do so at least 48 hours before your scheduled appointment time. A charge ranging from $50 to $100 may be applied to patients who miss their appointment or do not notify our office of a cancellation 48 hours in advance. The amount of funds charged will be depended on the time allotted for that specific appointment.**

For your convenience we will remind you of your appointment via email and text messages in advance. So as a courtesy to our practice, we will appreciate it if any changes to your appointments be made within 48 hours. Thank you.

I have read and understand the financial and cancellation policy statement. I agree to make prompt payment when billed for any or all charges not covered by the valid insurance benefits for and in consideration of services rendered.

By signing this agreement I, _____, give permission to Dr. Edward Moon to charge my credit card without any notice to me either $50 to $100 if I do not notify his office any changes of my upcoming appointment in 48 hours in advance.

Visa/Master#_____ Expiration:_____ Billing Zip Code;_____

Signature:_____ Date:_____

Health Information Privacy Policies & Procedures (HIPAA)

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

We implement these procedures as a matter of sound business practice; to protect the privacy of our patients; and to fulfill legal obligations under Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and all other state law that provides greater protection or rights to patients than the Privacy Rules.

As a member of our team, you are obligated to follow these Health Information Privacy Policies and Procedures faithfully. Failure to do so can result in discipline action, including termination of your employment or affiliation with us.

These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. They sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

Please note these rules not only apply to the "patient", but also to all family members including parents, step-parents, grandparents, etc. Rules also apply to prospective patients, and their authorized representatives.

If you have any doubts or questions about the use or disclosures of health information on any of our patients, consult your Office Manager or Executive Director immediately.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Print Name:_____ Signature:_____ Date:_____