Huixin Wang, D.D.S., M.S.
833-G Rockville Pike
Rockville, MD 20852
(301) 279-2501

Patient Information Form Date ______________

Patient Name____ Preferred Name________________________
First Middle Last

Address ____City ________________ State _____ Zip Code ___________

Home #____________________________ Cell # ____________________________ SS# ______________________

Sex M____F____ Birth Date _______________ Email ____

Would you like to be contacted through text? Yes____ No_____ Email? Yes_____ No_____

Check appropriate box Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

Spouse or parent's name _______________________________________ Work # _____________________________

Who may we thank for referring you? ____

In case of an emergency, who should be notified? ___________________________ Phone # ______________________

Responsible Party

Name of person responsible for this account ______________________________ Relationship to patient _________________

Address (if different from patient's)_____________________________________ Home # _____________________________

Driver's License # ___________________________ Birth Date ______________ SS# ________________________________

Insurance Information

Name of insured ____ Relationship to patient ______________

Birth Date ________________________ SS# _________________________________ Date employed ____________________

Employer ____ Work # _________________________

Insurance Co. _______________________________ Tel. # _____________________ Group #_________________________

Member ID # ________________ Ins. Co. address ____

Do you have additional insurance? If yes, complete the following:

Name of insured ____ Relationship to patient ______________

Birth Date ________________________ SS# __________________________________ Date employed ___________________

Employer ____ Work # __________________________

Insurance Co. ______________________________ Tel. # _______________________ Group #__________________________

Member ID # ________________________ Ins. Co. address ____

The information on this form is for our records only and is considered strictly confidential

Medical History

Physician ______________________ Date of last visit ______________________

Address ______________________ Phone # ______________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?______________________

Yes No Have you had a major operation? ______________________

Yes No Have you ever had a serious head or neck injury? ______________________

Yes No Do you take, or have you taken, Phen-Fen or Redux? ______________________

Yes No Have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes No Are you on a special diet?

Yes No Do you use tobacco?

Female patients only: Are you…

Pregnant? Yes No | Nursing? Yes No | Taking contraceptives? Yes No

If you are you allergic to any of the following, please circle.

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes, please explain ______________________

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

□ AIDS/HIV positive	□ Cortisone Medicine	□ Hemophilia	□ Renal Dialysis
□ Alzheimer's Disease	□ Diabetes	□ Hepatitis A	□ Rheumatic Fever
□ Anaphylaxis	□ Drug Addiction	□ Hepatitis B or C	□ Rheumatism
□ Anemia	□ Easily Winded	□ Herpes	□ Scarlet Fever
□ Angina	□ Emphysema	□ High Blood Pressure	□ Shingles
□ Arthritis/Gout	□ Epilepsy or Seizures	□ Hives or Rash	□ Sickle Cell Disease
□ Artificial Heart Valve	□ Excessive Bleeding	□ Hypoglycemia	□ Sinus Trouble
□ Artificial Joint	□ Excessive Thirst	□ Irregular Heartbeat	□ Spina Bifida
□ Asthma	□ Fainting Spells/Dizziness	□ Kidney Problems	□ Stomach/Intestinal Disease
□ Blood Disease	□ Frequent Cough	□ Leukemia	□ Stroke
□ Blood Transfusion	□ Frequent Diarrhea	□ Liver Disease	□ Swelling of Limbs
□ Breathing Problem	□ Frequent Headaches	□ Low Blood Pressure	□ Thyroid Disease
□ Bruise Easily	□ Genital Herpes	□ Lung Disease	□ Tonsillitis
□ Cancer	□ Glaucoma	□ Mitral Valve Prolapse	□ Tuberculosis
□ Chemotherapy	□ Hay Fever	□ Pain in Jaw Joints	□ Tumors or Growths
□ Chest Pains	□ Heart Attack/Failure	□ Parathyroid Disease	□ Ulcers
□ Cold Sores/Fever Blisters	□ Heart Murmur	□ Psychiatric Care	□ Venereal Disease
□ Congenital Heart Disorder	□ Heart Pacemaker	□ Radiation Treatments	□ Yellow Jaundice
□ Convulsions	□ Heart Trouble/Disease	□ Recent Weight Loss	

Have you ever 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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, Parent or Guardian:

______________________ Date ______________________

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Dental History

Reason for visit ____ Date of last visit ____________________________

What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____

Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________________________________

Yes No Have your wisdom teeth been removed? ____

Yes No Have you ever lost or chipped any teeth? ____

Yes No Have there been any injuries to face, mouth, or teeth? ____

Yes No Is any part of your mouth sensitive to temperature? Where? ____

Yes No Is any part of your mouth sensitive to pressure? Where? ____

Yes No Do your gums bleed with you brush? ____

Yes No Do you have any type of thumb or tongue habit? ____

Yes No Are you a mouth breather? ____

Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning? _____________________________

Yes No Are you aware of your jaw clicking or popping? ____

Yes No Are you aware of clenching your teeth during the day? ____

Yes No Have you been told that you grind your teeth? ____

Yes No Do you like the appearance of your smile? ____

Financial Agreement

Thank you for choosing Dr. Huixin Wang D.D.S., M.S. for your dental health needs.

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so we would like to explain our financial options. Please choose the option that works best for you.

1. Payment is due at the time treatment is rendered. We accept cash, American Express, Discover, MasterCard, and Visa.

2. Dental Insurance - As a courtesy to you, we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments, we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you received from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within

45 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Minor Patients - The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

Statements - All patients with an outstanding balance will receive a statement each month. All accounts with balances over 90 days will be subjects to our collection agency.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 29% of the debt, and all costs and expenses, including reasonable attorney's fees that we incur in such collection efforts.

Returned checks - A fee of $25.00 will be charged for any returned checks.

I assign directly to Dr. Huixin Wang, D.D.S., M.S. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not my insurance pays for services rendered. I authorize the use of my signature on all insurance submissions. Wintergreen Family Dental practice may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent, I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Dr. Huixin Wang D.D.S., M.S. to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form, please let us know.

Please print the patient's full name ____ Date ______________

Name of Guardian ____

Signature of patient, parent, or guardian:____

Patient HIPAA Consent Form

I understand that as part of my healthcare, Huixin Wang, DDS MS originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for my future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- And a tool for routine healthcare options such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to the change, the office will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request a restriction as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Print Patient Name ____ Date ______________________

Signature ____

Relationship to Patient ____

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