Harold Chen D.D.S.
Jing Zhao D.D.S.

86 -16 Whitney Ave. Elmhurst, NY 11373
T: (718) 651-6581
www.gpdental.nyc

GPdental

PATIENT REGISTRATION

Patient Name:_____ Sex: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Mandarin ☐ Cantonese ☐ Fuzhou

Date of Birth: _____ / _____ / _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____City: _____State: _____ Zip Code: _____

Phone #: (_____) _____ - _____ Cell#: (_____) _____ - _____ Work #: (_____) _____ - _____

Email Address: _____

Reason for visit: _____

How did you hear of us? _____

Insurance

Dental Insurance: _____ Dental Insurance #2: _____

Policy#:_____ Group#: _____ Policy#:_____ Group#: _____

Phone #: (_____) _____ - _____ Phone #: (_____) _____ - _____

Insured Persons Name:_____ Insured Persons Name:_____

Patient History check all that apply

☐ Asthma

☐ Autism

☐ Breast Feeding

☐ Diabettes

☐ Excessive Bleeding

☐ Heart Attacks

☐ Heart Disease

☐ Hepatitis

☐ High/Low Blood Pressure

☐ HIV/AIDS

☐ Stroke

☐ Smoker

Any Major Surgery?

What / When: _____

Are you allergic to:

☐ Penicillin

☐ Aspirin

☐ Others

☐ Behavior Disorders

(Autism / other):_____

☐ Pregnant

Weeks Pregnant: _____

Current Medication: _____

Blood Thinners: _____

Bisphosphonates:_____

Patient/Guardian Signature: **Date:**

_____ _____ / _____ / _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date _____ / _____ / _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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GP DENTAL TERMS & CONDITIONS OF TREATMENT PATIENT CONSENT

Patient Name: _____

I have received and read the document entitled A Patient's Guide to Services and agree to abide by its terms. I understand that it is my responsibility to inform GP Dental of any information concerning my **health or physical and mental condition** that may be relevant to my care.

I hereby authorize GP Dental and voluntarily consent to diagnosis, the recommendations for therapeutic treatment, and treatment by GP Dental. I will be advised of and fully understand the nature of the dental services to be provided. I will also be advised of: and understand fully, the risks and benefits that normally result from and are involved in the performance of the dental services.

I hereby give my free and voluntary consent that this treatment and any other treatments or procedures which are deemed necessary or advisable during the course of this treatment be performed. I have not been given any promises or guarantees as to the results to be obtained from this treatment. I understand that I may refuse to consent to any and all treatments or procedures that may be recommended, including those specified in the treatment plan.

I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I have read this Consent form, and I understand it.

Patient's Signature _____ **Date** _____ / _____ / _____
(IF A MINOR, PARENT OR LEGAL GUARDIAN)

FINANCIAL AGREEMENT

As a condition for treatment at GP Dental, financial arrangements must be made in advance. Patients are responsible for the cost incurred for the dental treatment agreed upon by the patient. Patients who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for the payment of their dental care. GP Dental will help prepare insurance forms or assist the patient in collecting from the insurance companies. However, GP Dental cannot render services on the assumption that the charges will be paid by the insurance companies.

I have read the above conditions concerning payment and voluntarily agree to the above conditions.

_____	_____	_____ / _____ / _____
Signature of patient, parent, or guardian	**Relationship to Patient**	**Date**
_____	_____	_____ / _____ / _____
Signature of guarantor of payment / responsible party	**Relationship to Patient**	**Date**