JOHNNY C. KO, DDS & JESSICA L. WANG, DDS ◦ 61 PEYTON PKWY, SUITE 101 ◦ COLLIERVILLE, TN 38017 ◦ 901-854-5527

NEW PATIENT FORM

Full Name: _____ Date: _____

SSN: _____ ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Occupation: _____ Employer: _____

City: _____ State: _____ Phone: _____

Spouse Name: _____ SSN: _____ DOB: _____

Employer: _____ City: _____

State: _____ Zip: _____ Phone: _____

Referred By: _____

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____ Date of Last Exam: _____

Are you currently under the care of a physician? ☐Yes ☐No

If YES, please explain: _____

Are you currently taking any prescribed drugs by a physician or dentist? ☐Yes ☐No

If YES, please describe: _____

FOR WOMEN: Are you pregnant? ☐Yes ☐No

DO YOU NEED TO PREMEDICATE BEFORE ANY DENTAL TREATMENT? ☐Yes ☐No

Have you ever had any of the following medical conditions or problems? Please check all that apply.

☐ Heart Attack/ Stroke	☐ Drug/ Alcohol Abuse	☐ Cancer/ Chemotherapy
☐ Diabetes	☐ Psychiatric Problems	☐ HIV+/ AIDS
☐ Temporomandibular Joint (TMJ)	☐ Chronic Hepatitis	☐ Shingles
☐ Heart Murmur/ Rheumatic Fever	☐ Anemia	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Hemophilia/ Abnormal Bleeding	☐ Kidney Problems
☐ Heart Surgery/ Pacemaker	☐ Severe Headaches	☐ Epilepsy/ Seizures/ Fainting
☐ High/ Low Blood Pressure	☐ Fever Blisters	☐ Tuberculosis (TB)

Are you allergic to any of the following drugs? Please check all that apply.

☐ Penicillin	☐ Codeine	☐ Tetracycline
☐ Erythromycin	☐ Aspirin	☐ Dental Anesthetics

Do you have dental insurance? ☐Yes ☐No

If YES, please provide name of ins. Company: _____ Group #: _____

Is this insurance through you or your spouse? _____

Do you have any other dental coverage? _____

If YES, please provide insurance company: _____

I understand that the information that I have given today is correct to the best of my knowledge, I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

PATIENT CONSENT (ADULT FORM)

CLINICAL

1. I authorize Johnny C. Ko, DDS & Jessica L. Wang, DDS (the Practice) to perform all recommended treatment, including but not limited to:
    a. All recommended treatment.
    b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis.
    c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

FINANCIAL

2. I am responsible for payment for all services rendered. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional costs, including reasonable attorney fees.

MAINTAINING APPOINTMENTS

3. I am aware that when appointments are broken or cancelled at the last minutes, valuable clinical time is voided, time that could have been spent serving another patient, especially a patient in pain. A $50 missed appointment fee will be charged to my account for all missed appointments or last-minute cancellations by me. I am aware that to hold down operating costs, a 24-hour notice minimum of cancellation is required.

INSURANCE

4. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as :signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

HIPAA ACKNOWLEDGEMENT

5. I authorize the Practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my care, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.
6. I acknowledge receipt of the Notice of Privacy Practices.
7. I authorize sharing my protected health information with the following individuals who may be involved in my care and I understand that I am responsible to notify the Practice of any changes:
    a. Name: _____ Relationship: _____
    b. Name: _____ Relationship: _____
    c. Name: _____ Relationship: _____
8. I authorize the following means of communication:
    a. Home Number: _____ to include a voice message
    b. Mobile Number: _____ to include a text or voice message
    c. Email: _____ Other: _____

SIGNATURE: _____ **DATE**: _____

PATIENT CONSENT (MINOR/CHILD)

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPAA Acknowledgement section below.

Your Child(ren)'s Names:

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

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6. I acknowledge receipt of the Notice of Privacy Practices.
7. I authorize sharing my child's protected health information with the following individuals who may be involved in my child's care and I understand that I am responsible to notify the Practice of any changes:
    a. Name: _____ Relationship: _____
    b. Name: _____ Relationship: _____
    c. Name: _____ Relationship: _____
8. I authorize the following means of communication:
    a. Home Number: _____ to include a voice message
    b. Mobile Number: _____ to include a text or voice message
    c. Email: _____ Other: _____

PARENT/LEGAL GUARDIAN'S SIGNATURE: _____ **DATE**: _____

PAYMENT GUIDELINES

In an effort to keep fees low and be fair to everyone concerned, we have been advised to adopt the following payment guidelines.

- The parent or guardian who accompanies the child is responsible for payment at the time of services.
- Payment should be made at the time services are received.
- If you have dental insurance, we ask that you take care of your part (deductible and co-payments) at the time services are received.
- Any amount unpaid by insurance is the patient's responsibility.
- If there is an outstanding balance, that balance is due in full upon receipt of a statement.
- Balances over 30 days old may be subject to a billing charge.
- Payment may be made by Cash, Check, or Credit Card (VISA, MasterCard, or American Express).
- All broken appointments will be charged a fee.

SPECIAL FINANCING

(FOR BALANCES IN EXCESS OF $200)

- Minimum monthly payment is $50.
- Payments should be received by the 10th of the month.
- Payments received after the 15th are considered late. Returned check fee is $15.
- A billing charge will be added each month there is a balance.
- Crowns, fixed bridges, dentures, and partials require 50% initial payment.
- Missed payments will be added to the next month's payment.
- Two consecutively missed payments will void this agreement and the total balance will be due.
- I understand that a credit history report may be obtained if special financing is necessary.
- I understand that I will be responsible for any court costs, collection fees, and legal fees in the event that this account is referred to a collection agency or to an attorney.

I HAVE READ AND UNDERSTAND THE PAYMENT GUIDELINES AND THE SPECIAL FINANCING AND AGREE TO THE TERMS AND CONDITIONS HEREIN.

SIGNATURE: _____ DATE: _____

Johnny C. Ko, DDS & Jessica L. Wang, DDS

61 Peyton Pkwy, Suite 101 ▪ Collierville, TN 38017 ▪ (901) 854-5527