H. Elaine Cheong, DDS
GENERAL DENTISTRY

℗ (573) 499-0300
℻ (573) 499-9088
cheongdds@mediacombb.net

1000 W. NIFONG BLVD.
BLDG. 8, STE. 120
COLUMBIA, MO 65203

Welcome to the office of Dr. H. Elaine Cheong!

OUR PHILOSOPHY

We understand that every patient has different dental health care needs. To achieve our goal of nurturing your teeth, mouth, and gums to be the healthiest they can be, we actively involve and depend on YOU during and after the course of your treatment. We value gentleness and transparency, so please let us know how we can make your visit as comfortable as we can.

OUR LATE & CANCELLATION POLICIES

We operate by appointments. We try our best to stay on time so we can give our patients the best quality care, and to do so, we need our patients to be on time for their scheduled appointments.

- If you are not able to keep your appointment, please notify us at least 1 full business day in advance. If we do not receive a cancellation notice, you will be charged $35.00.
- If you are more than 15 minutes late for your appointment, we may ask you to reschedule.

OUR INSURANCE AND PAYMENT POLICIES

We will file the insurance claim for you, but because insurance is a contract between you and your insurance carrier, we cannot guarantee that your insurance carrier will pay for your treatment.

- At the time of service, we ask that you pay your deductible and co-payment.
- We will try to provide a "pre-treatment estimate" to give you a sense of what you will need to pay.
- After your insurance company processes payments, it will be your responsibility to pay any remaining balances.

FOR PEDIATRIC PATIENTS

Patient accounts for patients under the age of 18 will be in the name of the parent/guardian who brings them to the initial visit or signs their consent form. This person will be financially responsible for the account. If another party will be making payments on her/his behalf, the person responsible for the account must complete a Payment Authorization Form to allow us to charge another individual for services rendered. We ask that all patients under the age of 18 be accompanied by a guardian during all visits, so that the medical history can be updated and signed.

We strive to provide quality and gentle dental care and hope your experience with us is a pleasant one. Please don't hesitate to ask questions to our staff. We look forward to getting to know you!

Patient or Guardian Signature: _____ Date: _____

H Elaine Cheong, DDS
GENERAL DENTISTRY

New Patient Form

WELCOME TO OUR OFFICE!

PERSONAL INFORMATION

Patient Name (First, Last): _____ Preferred Name: _____

DOB: _____ Age: _____ Sex: M / F SSN: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Spouse Name (First, Last): _____

Emergency Contact Name (First, Last): _____ Relationship: _____

Emergency Contact Phone Number: _____

Person Responsible for Account (If Not Self): _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship to Patient: _____

Member ID: _____ Policy Holder SSN: _____

Group Number: _____ Secondary Insurance? No / Yes: _____

DENTAL HISTORY

Last Dental Visit: _____ Previous Dentist (Optional): _____

Check All That Apply:

- ☐ Grind/clench teeth
- ☐ Wear a night guard
- ☐ Popping or clicking of the jaw
- ☐ Orthodontics (braces)
- ☐ Periodontal surgery or treatment (deep cleaning)
- ☐ Have to take an antibiotic before dental appointments
- ☐ Drink coffee, tea, and/or soda
- ☐ Smoke or chew tobacco

Primary Reason for Visit (Circle One): Exam and Cleaning Emergency Consult

Whom can we thank for referring you? _____

Patient or Guardian Signature: _____ Date: _____

H. Elaine Cheong, D.D.S., L.L.C.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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:

X Date:_____

H. Elaine Cheong, DDS
GENERAL DENTISTRY

(573) 499-0300
(573) 499-9088
cheongdds@mediacombb.net

1000 W. NIFONG BLVD.
BLDG. 8, STE. 120
COLUMBIA, MO 65203

Consent for Use and Disclosure of Health Information

PLEASE READ THE FOLLOWING CAREFULLY:

- PURPOSE OF CONSENT: By signing this form, you consent to our use and disclosure of your protected health information to render dental treatment, administer payment activities, and coordinate any related healthcare conditions.

- NOTICE OF PRIVACY PRACTICE: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent form. Our notice provides a description of our treatment and payment activities, healthcare operations, the use and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent form. We encourage you to read it carefully and completely before signing this consent form.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices.

For questions regarding our Notice of Privacy Practices, including any revisions of our notice, please contact:

Contact Person:	H. Elaine Cheong, DDS
Address:	1000 W. Nifong Blvd. Bldg. 8, Ste. 120 Columbia, MO 65203
Phone:	(573) 499-0300
Fax:	(573) 499-9088

"I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations."

Patient/Guardian Signature for Consent: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

PATIENT REVOCATION: You have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this consent will not affect any action we took in reliance on your consent before receiving your revocation, and that we may decline to treat you or continue treatment if you revoke this consent.