eten dental
이튼치과
218-14 Northern Blvd. #104 Bayside, NY 11361
Tel: 718-423-1010 Fax: 718-423-1011
www.etendental.com

Dr. Eju Hwang D.D.S.

Patient #:

PATIENT INFORMATION (Confidential)

Date:_____/_____/_____

Patient's Name: _____ Birthdate_____/_____/_____

Patient's Social Security No:_____ Sex: Male Female

Address_____

City_____ State_____ Zip_____ Email: _____

Phone No: Home: _____ Cell:_____Work:_____

Insurance: Yes / No Relation to Policy Holder:_____

Whom may we thank for referring you?_____

INSURANCE POLICY HOLDER'S INFORMATION

Insurance Company _____ Policy ID: _____

Name Insured_____Birthdate_____/_____/_____

Policy Holder's S.S#_____ Sex: Male Female

Policy Holder's Address: _____

Name of Employer_____Work Phone No:_____

Address of Employer_____

Better Teeth Better Smile Better Life, Eten Dental!

PATIENT MEDICAL HISTORY

List the medications you currently take:_____
□□ □□□□ □□ □ □□□ □□□□.

Do you have allergies to any medications? Yes / No If Yes, what Medicines? _____
□□□ □□□ □□□ □□□□? □□ □ □□□?

List all major illnesses._____
□□□ □□ □□□□ □□□□.

List any surgery you had._____
□□□□ □□□ □□□□.

Do you currently have any problems in the following areas? Please check on yes if have.
□□ □□□ □□□□□ □□□□ □□□□□? □□□□, □□□□ □□□□□□.

	Yes	No
High Blood Pressure…….. □□□	☐	☐
Diabetes…….. □□	☐	☐
Heart Trouble…….. □□□	☐	☐
Asthma…….. □□	☐	☐
Heart Murmur…….. □□□	☐	☐
Stroke…….. □□□	☐	☐

	Yes	No
Heart Attack…….. □□□□	☐	☐
Joint Replacement……. □□□□	☐	☐
Hip Replacement…….. □□□□□	☐	☐
Mitral Valve Prolapse…… □□□□□□	☐	☐
Kidney Disease…….. □□□	☐	☐
Hepatitis…….. □□	☐	☐

	Yes	No
Lung Disease…….. □□□	☐	☐
Liver Disease…….. □□□	☐	☐
Cancer…….. □	☐	☐
AIDS or HIV Infection…… □□□	☐	☐
Other…….. □□	☐	☐

HIPPA COMPLIANCE

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by Eju Hwang, D.D.S., Eten Dental P.L.L.C.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or dental care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our HIPPA Notice of Privacy Practices.

Patient's Name: _____Signature_____Date:_____
□□ □□ □□ □□(□□□□□ □□ □□□ □□)

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Eju Hwang D.D.S., Eten Dental P.L.L.C. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Eju Hwang D.D.S., Eten Dental P.L.L.C. insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor)_____ Date_____
□□ □□ (□□□□□ □□ □□□ □□) □□