



Yoon H. Chang, DDS, MS

Patient's Name: First _____ Last _____

Gender: Male/ Female, DOB ____/____/____ Age: _____ Social Security number: _____

Home Address, City, State, Zip Code: _____

Phone (____) _____ Text (yes, No) Email: _____

School Attending: _____ Hobbies/Interests: _____

Occupation: _____ Home/Cell Phone: (____) _____

Name of family dentist, phone number: _____

Who may we thank for referring you to our office? _____

<Account Responsible Party>

First Name: _____ Last Name: _____

Gender: M F Relationship with the patient: _____ DOB: ____/____/____ SSN: _____

Home Address: _____

Cell Phone: (____) _____ Email: _____

<Insurance>

Insurance Carrier: _____ Name of Policy Holder: _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security No. _____

Policy Number: _____ Group Number: _____

Do you have Orthodontic Coverage: Y , N Max _____ Age limit _____ Deductible _____

***** Initial Consultation (to be paid before consultation): starting at \$100. Any additional photos, x-rays, and more will be an additional cost. Information during the consultation including photos, etc. is not releasable or transferrable except for our own active patients.**

The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. Your signature below indicates that You understand and accept this policy. You herein authorize payment of dental benefits to the Doctor when an assigned claim is filed.

Patient/ Legal Guardian Signature: _____ Date: _____

Phone Number: _____ Relationship to patient _____

Findings Initial-Diagnostics

Name _____ Date _____

Main concern _____

Special Medical Analysis

Do you have or did you ever have an illness with regard to points 1-12?

	yes	no		yes	no
1. Infections			7. Urogenital problems		
2. Cardio-vascular systems			8. Central nervous systems		
3. Respiratory systems			9. Psychological problems (therapy)		
4. Digestive systems			10. Rheumatic disease		
5. Metabolic systems			11. Hormonal disease		
6. Allergies			12. Special problems		

	valuation	yes	no
1. Do you have problems when you chew?			
2. Do you have problems when you are talking?			
3. Do you have problems in closing your teeth properly?			
4. Are any of your teeth especially sensitive?			
5. Do you have a problem when you open your mouth very wide?			
6. Do your jaw joints make noise and if so, on what side?			
7. Do you have pain in the area of your jaw joints?			
8. Do you suffer from headaches?			
9. Do you suffer from cramps or spasm in your head, neck or throat?			
10. Do you have in general problems with your posture?			
Occlusal Index	0.00		

	yes	no
11. Have you ever had a serious accident?		
12. Did you have one or more oral intubations?		
13. Have you ever had orthodontic treatment or...		
14. Have you had a treatment with a splint?		
15. Are you grinding or pressing with your teeth?		
16. Do you think that treatment is necessary?		
17. Do you think that there is a serious disorder or illness?		

18. When was the last time you had dental treatment and what was done?

19. How would you describe your psychic behaviour?
 happy sad calm excited self-controlled lack of self control

Dental History Analysis – Occlusal Index

	Y	N	Details
1. Are you pregnant, possibly pregnant, or breastfeeding?			
2. Are you currently receiving treatment from a doctor, hospital, or clinic?			
3. Do you suffer from allergies, including hay fever, eczema, any medicines (e.g. penicillin), substances (e.g. latex/rubber), or foods? Or have you got a history of adverse effects on dental materials? Please give details			
4. Are you carrying a medical warning card?			
5. Do you suffer from bronchitis, asthma, or other chest conditions?			
6. Do you suffer from fainting attacks, panic attacks, giddiness, blackouts, or epilepsy?			
7. Do you suffer from heart problems; Have a pacemaker, angina, heart murmur, blood pressure problems, or stroke? Have you ever had rheumatic fever? If so, which?			
8. Are you diabetic?			
9. Do you suffer from arthritis?			
10. Do you suffer from bruising or persistent bleeding following injury, tooth extraction, or surgery?			
11. Do you suffer from any infectious diseases (including HIV and hepatitis)?			
12. Have you ever had liver disease (e.g. Jaundice, hepatitis) or kidney disease?			
13. Have you ever had Blood Refused by the Blood Transfusion Service? If so why?			
14. Have you ever had a bad reaction to general or local anesthetics?			
15. Have you ever had heart surgery or brain surgery? Which?			
16. Do you have any close relatives (parent, sibling, child, grandparent, or grandchild) with Creutzfeldt Jacob Disease (CJD), or received growth hormone treatment before the mid-1980s?			
17. Have you ever had radiation therapy on your head or neck?			
18. Do you have a history of mental health problems?			
19. Do you now, or have you ever, suffered from any eating disorders?			
20. Do you suffer from Gastro-esophageal or Acid Reflux?			
21. Any other conditions not listed here?			
22. Do you take Bisphosphonate medication for your bones? Have you in the past? Are you likely to in the future? (for osteoporosis/steroid use / bone cancer / Padgett's disease)			

**3D Cone Beam CT Imaging Consent/Acknowledgment/Release and
Waiver of Scope of Services**

I, _____, hereby consent to Dr. Yoon Chang at E Line Orthodontics to take 3D cone beam imaging on (patient name) _____ to provide tentative orthodontic treatment options.

I was explained that the ICAT 3D Cone Beam Imaging quick scan will produce a radiation dosage equivalent to 6-7 days of ordinary background average radiation. I further understand that the purpose of taking 3D imaging is ONLY to provide **orthodontic treatment options** and NOT a professional interpretation or diagnosis of any craniofacial structures, surrounding soft tissue, or associated pathologies.

In consideration of the waiver of all costs and services through Dr. Yoon Chang at E Line orthodontics, I do hereby, or on behalf of (patient name) _____, now and forever release and discharge Dr. Change, his agents, employees, professional corporation, insurers and assigns from any loss, costs, damages or expenses arising out of taking 3D Cone Beam CT Imaging, advice, diagnoses, and treatment by said Doctor, his/her agents or employees to Patient.

This form and the consideration recited herein are not and shall not be constructed to be an admission of liability on the part of anyone, including, but not limited to, said Doctor, his/her agents, or employees.

There will be a \$250 fee for duplication of imaging and release. There's no copay to the patient for taking this image however, it will be E Line Orthodontics' property which is not transferable until his/her orthodontic treatment starts at E Line Orthodontics

Patient/ Legal Guardian Name: _____ Date _____

Signature: _____

Privacy Consent Form

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, demographic data, etc.) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation, and licensure).

We may call, write, email, or text to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, write, email, or text to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will email you an appointment reminder and/or leave you a reminder message on your cell phone or home answering machine or with someone who answers your phone if you are not home.

You have the right to request restrictions on using your protected health information. However, we are not required to, and the changes may not be implemented prior to the effective date of the revised notice. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on the Consent. You have the right to review our office's privacy notice prior to signing this Consent; a copy will be given to you upon request.

Thank you for your cooperation. Please let us know if you have any questions.

Patient/ Legal Guardian Name: _____

Responsible Party Signature: _____

Dental Record Release

E-line Orthodontics recognizes the patient's right to confidentiality of protected health information as set forth in federal and Texas state law.

All releases based on this form are limited to records dated up to and including the date of the patient/responsible party's signature. A new authorization is necessary for the release of information on care provided after the date of the patient/responsible party's signature unless you (the patient or responsible party) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

I, _____, hereby authorize the doctor and staff of E Line Orthodontics to release records or knowledge concerning my dental health to the referring doctor(s).

Name of Patient/Guardian _____ Date _____

Signature _____

Healthcare Physician Information

Please list all healthcare physicians whom the patient is currently in the care of.

Name of doctor or the clinic: _____

Phone Number: _____

What specialty is this patient seeing for:

Name of doctor or the clinic: _____

Phone Number: _____

What specialty is this patient seeing for:

Name of doctor or the clinic: _____

Phone Number: _____

What specialty is this patient seeing for:

Name of doctor or the clinic: _____

Phone Number: _____

What specialty is this patient seeing for:

