PATRICK C. LEE D.D.S., M.S., INC.
Orthodontics for Children & Adults

ADULT NEW PATIENT FORM

First Name: _____ Last Name: _____ Nick Name (if preferred) _____

Date of Birth: ___ - ___ - ___ Age _____ ❑ Female ❑ Male SS #: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Domestic Partner DL #: _____ *State:* _____

Home Address: _____ Email: _____

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

Employer: _____ Employer Address: _____

Occupation: _____ How Long: _____

In Case of Emergency, who should we contact? Name: _____ Phone #: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

INSURANCE INFORMATION

Members Name: (First) _____ (Last) _____

Member ID # (SS#): _____ Date of Birth: _____

Relation to Patient: ❑ Self ❑ Spouse ❑ Other Other (explain): _____

Insurance Carrier: _____ Insurance Phone: ( ) _____

Insurance Address: _____

Group, Plan or Policy #: _____ Employer: _____

➤➤➤ **Please advise us if you have Secondary Orthodontic Insurance** ➤➤➤

ALTERNATE BILLING *(please fill out this section if individual listed above is not financially responsible)*

Person(s) Responsible for Account: _____ Relation: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext: _____

Billing Address: _____

SS #: ___ - ___ - ___ Driver License #: _____ *State:* _____ Employer: _____

Employer Address: _____

Our office reserves the right to verify the credit status of potential patients and/or financially responsible parties of potential patients prior to extending credit for treatment fees and may, at our discretion, use one or more credit reporting agencies. I understand I am responsible for payment of services rendered. If my insurance is accepted, I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize this office to submit insurance billing on my behalf with assignment of benefits made to this office, for services rendered. I understand the information I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence, and it is my responsibility to update this office of any changes contained herein.

Patient Signature: _____ **Date:** _____

MEDICAL HISTORY FORM - ADULT

Patient Name: _____ DOB: ___ - ___ - ___ Age: _____

Name of General Dentist: ***Dr.*** _____ Address: _____

Dentist Phone: ( ) _____ Date of your last dental cleaning? _____

What is your attitude towards dentists? *(ex: fearful, shy, looks forward to…)* _____

Medical History

❑ Yes ❑ No Currently under the care of a physician? Name: _____ Address: _____

Please explain: _____

❑ Yes ❑ No Currently taking any medications? *Please list:* _____

❑ Yes ❑ No Allergic to aspirin, codeine, anesthetic, amoxicillin/penicillin, erythromycin, sulfa drugs, latex, nickel or any other medications?

Please list: _____

❑ Yes ❑ No Ever had any serious medical condition, illness, or hospitalization? *Please explain:* _____

If female, are you? ❑ Pregnant ❑ Nursing ❑ Taking birth control pills

Have you ever had any of the following medical conditions?

❑ Yes ❑ No	Heart defects / problems / surgery	❑ Yes ❑ No	Blood disorders, excessive bleeding	❑ Yes ❑ No	Cancer / chemo / radiation tx
❑ Yes ❑ No	Artificial valve / joint	❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Bone disorders
❑ Yes ❑ No	Heart murmur	❑ Yes ❑ No	Blood transfusion / organ transplant	❑ Yes ❑ No	Arthritis
❑ Yes ❑ No	Rheumatic / scarlet fever	❑ Yes ❑ No	Nervous system problems	❑ Yes ❑ No	Glaucoma
❑ Yes ❑ No	Heart attack / angina / stroke	❑ Yes ❑ No	Fainting spells, seizures	❑ Yes ❑ No	Liver problems, hepatitis
❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No	Recurrent headaches	❑ Yes ❑ No	Ulcers, Colitis
❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Psychiatric care	❑ Yes ❑ No	Kidney problems
❑ Yes ❑ No	Lung problems, difficult breathing	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Sexually transmitted disease
❑ Yes ❑ No	Asthma, emphysema, bronchitis	❑ Yes ❑ No	Thyroid disease	❑ Yes ❑ No	Fever blisters, herpes
❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Immune disorders	❑ Yes ❑ No	Drug / alcohol abuse
❑ Yes ❑ No	Sinus problems, hay fever	❑ Yes ❑ No	HIV+ / AIDS		

Dental History

❑ Yes ❑ No Unhappy with the appearance of your teeth?

❑ Yes ❑ No Are you against wearing braces?

❑ Yes ❑ No Previous orthodontic treatment?

If so, with whom: _____

❑ Yes ❑ No Consulted an orthodontist before?

If so, with whom: _____

❑ Yes ❑ No Has dentist recommended treatment?

❑ Yes ❑ No Have any family members had treatment?

❑ Siblings ❑ Children ❑ Parents

❑ Yes ❑ No Mouth breathing while awake or asleep

❑ Yes ❑ No Speech problems

❑ Yes ❑ No Excessive cheek biting

❑ Yes ❑ No Excessive trapping of food between teeth

❑ Yes ❑ No Chipping of front teeth

❑ Yes ❑ No Grinding or wear on teeth

❑ Yes ❑ No Injuries to the face, mouth, or teeth

❑ Yes ❑ No Difficulty brushing or flossing

❑ Yes ❑ No Difficulty biting or chewing

❑ Yes ❑ No Difficulty in opening or closing the jaws

❑ Yes ❑ No Clicking or popping of the jaw

❑ Yes ❑ No Pain (jaw joint, ear, side of face)

❑ Yes ❑ No Missing or extra permanent teeth

❑ Yes ❑ No Tonsil and adenoids removed

❑ Yes ❑ No Biting / chewing habit (circle): toothpick, shirt, gum, ice, pen, pencil, fingernail, thumb, finger, lip, straw

❑ Yes ❑ No Smoke tobacco

❑ Yes ❑ No Play a musical instrument

❑ Yes ❑ No Play active sports

I understand that the information that I have provided is correct to the best of my knowledge. I will inform this office of any changes to my medical and dental health. I consent to the performing of oral examinations and other necessary dental services by the dental staff. This office is HIPAA, OSHA, CDC and ADA Compliant and are committed to upholding and exceeding the standards set by these entities.

Patient Signature: **Patient Name:** **Date:**

For Office Use Only: _____

Medical Hx Reviewed by: _____ Date: _____

PATRICK C. LEE, DDS, MS, INC.

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Member American Association of Orthodontists

CONSENT TO DIAGNOSTIC EXAMINATION & RECORDS
*** NEW PATIENTS ***

Patient Name _____ **Date** _____

The purpose of the diagnostic examination and records is to gather comprehensive information for Dr. Lee to perform an initial orthodontic screening, and to evaluate and recommend a treatment plan.

Photographs of the face and teeth are usually the first records taken. If indicated, one or more dental radiographs will be recommended by Dr. Lee in order to view the underlying bone and tooth development. The most common radiograph is the panoramic x-ray. (With the use of digital x-rays and protective aprons, minimal radiation exposure can be expected). In addition to examining the oral cavity, Dr. Lee may measure the periodontal (gum) pockets to check for gum disease, or take impressions of your teeth so he can have an exact replica for a more accurate diagnosis.

NON-COMPLIMENTARY PROCEDURES:

X-Ray(s): A discounted cash patient fee of $65 per x-ray will apply.

For patients utilizing insurance: Please note that the fee billed to your insurance is our usual and customary fee for the service(s) provided and will be higher than the discounted fee offered to our non-insurance (cash) patients. In accordance with our contract with your insurance, if your claim is accepted and paid in-part or in-full by your insurance, you will receive a check refund for any credits above the patient responsible amount.

Pre-Orthodontic Single Extraction Diagnosis and Referral - *A fee of $175 will apply for any Single Extraction Diagnosis and Referral prescribed by Dr. Lee. An extraction request will be made to the patient's dentist / oral surgeon upon review of complete records.*

ALL PATIENTS:	**Do you have a latex allergy?**	❑ YES	❑ NO	
FEMALE PATIENTS:	**Are you pregnant or suspect you may be pregnant?***	❑ N/A	❑ YES	❑ NO
	***X-Ray Advisory**			

ACKNOWLEDGEMENT & CONSENT

I agree to a clinical examination by Dr. Patrick Lee and staff, and the taking of any necessary diagnostic records, including facial and intra-oral photographs, dental radiographs (x-rays) for the purpose of diagnosis and treatment planning. I also agree to be fully responsible for the total payment of any applicable fees.

❑ Self ❑ Parent ❑ Legal Guardian

Signature ***Print Name*** ***Relation to Patient*** ***Date***

FOR OFFICE USE ONLY:

❒ Tx Chart ❒ Book X-Ray Appt ❒ Accounting

Amerige Heights Town Center • 1943 West Malvern Avenue • Fullerton, CA 92833 • **(714) 992-6288**
LeeOrthodontics.com

Dr. Patrick C. Lee

Informed Consent Regarding Covid-19

Patient: ***First & Last Name*** _____

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “Coronavirus,” at any time or in any place. Be assured that we have always, and will continue to follow state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our practice.

Despite our careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to Covid-19 in our office, just as you might be exposed at the gym, grocery store, restaurant or any public space. “Social Distancing” nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients, at all times.

Although exposure is unlikely, do you acknowledge and accept Covid-19 exposure risks associated with office visits?

❑ **Yes** ❑ **No**

Signer’s Name *(Parent Name if Patient is a Minor)* **Date**

_____ _____

Signature *(Parent Signature if Patient is a Minor)*

_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Patient Name

_____
Signature (Patient or Parent / Guardian)

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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PATIENT COPY TO KEEP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (1/1/04), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: PATRICK C. LEE, DDS, MS, INC.
Telephone: (714) 992-6288 Fax: (714) 992-6289
E-mail:
Address: 1943 West Malvern Avenue, Fullerton CA 92833

PATRICK C. LEE, DDS, MS, INC.

AMERIGE HEIGHTS TOWN CENTER • 1943 WEST MALVERN AVENUE, FULLERTON CA 92833 • 714.992.6288

LEEORTHODONTICS.COM

DIRECTIONS TO OUR FULLERTON OFFICE

HELPFUL TIP: Park at Islands Burger Restaurant parking lot and look for our "Orthodontics" signage on the back of our building.

BY FREEWAY

5 FREEWAY (SOUTH BOUND)

1. Exit Beach Blvd (CA-39), then turn left onto Beach Blvd.
2. In half a mile, turn right onto Commonwealth Blvd.
3. In two miles, just past the airport, turn left onto Gilbert St.
4. In one mile, you will see the Amerige Heights Town Center just past Malvern Ave on your right.
5. Turn right into the Center at Stern Goodman St.

5 FREEWAY (NORTH BOUND)

1. Exit Euclid St., then turn right onto Euclid St.
2. You will go past the 91 Fwy, and then in one mile, turn left onto Malvern Ave.
3. In one mile, you will see the Amerige Heights Town Center on your right. Do not turn until you see Albertson's Way, next to Islands Burger Restaurant.

91 FREEWAY (EAST BOUND)

1. Exit Beach Blvd, then turn left onto Beach Blvd.
2. In one mile, turn right onto Commonwealth Blvd.
3. In two miles, just past the airport, turn left onto Gilbert St.
4. In one mile, go just past Malvern St. and turn right into the Amerige Heights Town Center (Stern Goodman St.)

91 FREEWAY (WEST BOUND)

1. Exit Euclid St., then turn right onto Euclid St.
2. In one mile, turn left onto Malvern Ave.
3. In one mile you will see the Amerige Heights Town Center on your right. Do not turn until you see Albertson's Way, next to Islands Burger Restaurant.

57 FREEWAY (SOUTH BOUND)

1. Exit Imperial Hwy. Turn right onto Imperial Hwy.
2. Then make a quick left onto State College Blvd.
3. In one mile, turn right onto Bastanchury Road
4. You will go past Harbor Blvd, and then in two miles, Bastanchury will end at Malvern Ave. Turn right on Malvern.
5. In half a mile, you will see the Amerige Heights Town Center on your right. Do not turn until you see Albertson's Way, next to Islands Burger Restaurant.

BY STREET

FROM LA HABRA, ROWLAND HEIGHTS, HACIENDA HEIGHTS

Harbor Blvd: Travel south on Harbor Blvd

1. Turn right on Bastanchury Road
2. In two miles, Bastanchury will end at Malvern Ave. Turn right onto Malvern Ave.
3. In half a mile, your will see the Amerige Heights Town Center on your right. Do not turn until you see Albertson's Way, next to Islands restaurant.

FROM ANAHEIM, GARDEN GROVE, STANTON

Beach or Magnolia Streets: Travel north on Beach or Magnolia

1. You will go past the 91 Fwy, then turn right onto Commonwealth Blvd.
2. Turn left onto Gilbert St.
3. In one mile, go just past Malvern St. and turn right into the Amerige Heights Town Center (Stern Goodman St.)

Brookhurst Road: Travel north on Brookhurst Rd

1. You will go past the 91 Fwy, then turn left on Commonwealth Blvd.
2. Turn right onto Gilbert St.
3. In one mile, go just past Malvern St. and turn right into the Amerige Heights Town Center (Stern Goodman St.)

Euclid Street: Travel north on Euclid St.

1. You will go past the 91 Fwy, and then in one mile, turn left onto Malvern Ave.
2. In one mile, you will see the Amerige Heights Town Center on your right. Do not turn until you see Albertson's Way, next to Islands restaurant.