Derek J. Chang, DDS, PLLC
4758 McArdle Rd. Suite 204, Corpus Christi, TX 78411
361-992-7631

Patient Information

Date: _____ ☐ New Patient ☐ Update

Patient Name: _____ Preferred Name: _____ Title: _____
Patient's DOB: _____ Patient's SSN: _____
*If child, provide Parent/Guardian Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____
Email: _____
How did you hear about our office? _____

Emergency Information

In case of an emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Name: _____ Relationship: _____ Name: _____

Insurance Information

Employer Name: _____
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SSN: _____
Dental Insurance Carrier: _____ Patient's Insurance ID#: _____
Group/Policy#: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

As a courtesy to our patients, we submit insurance claims on behalf of our patients. If a patient has dual coverage, we will file to patient's primary policy only. You may choose to self-file to your secondary coverage and will need to contact your insurance representative to assist you in this matter. Your insurance policies will dictate which plan is considered Primary Coverage and Secondary Coverage. We are unable to choose which plan pays for.

Patient Consent- Payment Authorization- Signature on File

-To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medication change, I shall inform the dentist and staff at the next appointment without fail.

-I hereby authorize payment directly to Derek J Chang DDS PLLC of the dental benefits otherwise payable to me. -I hereby authorize Derek J Chang DDS PLLC to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/ or discussing treatment options with other dental professionals.

-I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By Signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature _____ **Date:** _____

Derek J. Chang, DDS, PLLC
4758 McArdle Rd. Suite 204, Corpus Christi, TX 78411
361-992-7631

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. To achieve these goals, we need our assistance and your understanding of our financial guidelines.

Insurance

We accept most major dental insurance payments; however, we may not be an in-network provider for your plan. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedure to a lesser reimbursement level, in which case, you would be responsible for the difference.

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

Patient portion or patient co-pay is due at the time services are rendered. Payment Information:

- All major credit cards are accepted (Visa, MasterCard, Discover)
- Cash, Personal Check (a $25 fee will be applied if a personal check is declined)
- CareCredit
- Loyalty Plan (for existing patients, see staff for details)

Cancelled/Missed Appointment (Must Read)

If you cannot make an appointment as scheduled, please notify our office. If you wish to cancel or reschedule your appointment, there must be a 24 hour notice. If your appointment is canceled or rescheduled the day of your visit or you NO-SHOW, there will a $50 reschedule/cancelation/No-Show fee that will need to be paid prior to scheduling any further appointments. As a courtesy to our patients, we will waive this fee on your first No-Show/Cancelation/ or Rescheduled Appointment less than 24Hr notice but any missed appointments afterwards will be subject the fee. We provide a 10 minute grace period after your appointment time, if you arrive after this time, we have the right to reschedule your appointment.

By signing below, I acknowledge that I have read and understand the guidelines above.

Signature: _____ **Date:** _____

DEREK J CHANG DDS PLLC NOTICE OF PRIVACY PRACTICES - Updated 2/11/26

Name of Person filling out Privacy Form: _____

Relationship to Patient: ☐ Adult ☐ Patient ☐ Parent ☐ Guardian ☐ Other

☐ I give permission for the following communications to be used Derek J Chang DDS PLLC:

☐ Cell Phone ☐ Text Message ☐ Reminders Permitted ☐ Email

☐ I am granting permission for Derek J Chang DDS PLLC to disclose their identity to anyone who may answer my contact number.

☐ I am granting permission for Derek J Chang DDS PLLC to leave a message with any person who may answer my contact number or on a voicemail.

☐ Cell Phone ☐ None- Please just ask for a call back ☐ Other (Please explain)

I would like to give permission for the following person(s) to bring to dental appointments and have access to personal information including but not limited to treatment and billing of myself and any dependent children listed above:

1) Name: _____ Patient's Relationship: _____

2) Name: _____ Patient's Relationship: _____

3) Name: _____ Patient's Relationship: _____

4) Name: _____ Patient's Relationship: _____

Signature **Date:**

OUR LEGAL DUTY

We are required by federal and Texas state law to maintain the privacy and security of your protected health information (PHI). We must provide you with this notice explaining our legal duties, privacy practices, and your rights regarding your health information.

We must follow the privacy practices described in this notice while it is in effect. This notice remains effective until replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as permitted by law. If we make a significant change, we will revise this notice and make the updated version available upon request and in our office.
You may request a copy of this notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may use and disclose your health information to dentists, physicians, specialists, and other healthcare providers involved in your care.
We may use and disclose your health information to obtain payment for services provided, including insurance billing and collections.
Healthcare Operations
We may use and disclose your information for operational purposes, including: Quality improvement, Staff training, Credentialing and licensing, Performance evaluation, Compliance and audits

YOUR AUTHORIZATION - Beyond treatment, payment, and operations, we will not use or disclose your health information without your written authorization. You may revoke authorization at any time in writing, except for disclosures already made.

DISCLOSURES TO FAMILY, FRIENDS, AND CAREGIVERS

We may disclose limited health information to individuals involved in your care or payment only if you agree or when permitted under HIPAA based on professional judgment.

If you are present, you will be given the opportunity to object. In emergencies or incapacity, disclosures may occur when deemed in your best interest.

MARKETING & COMMUNICATIONS

We will not use your health information for marketing purposes without your written authorization.
Appointment reminders and treatment-related communications are permitted as part of healthcare operations.

REQUIRED BY LAW
We may disclose your health information when required by law, including:
Public health reporting
Law enforcement requests
Judicial proceedings
Government audits
Workers' compensation
ABUSE, NEGLECT, OR SAFETY THREATS
We may disclose information to appropriate authorities if we reasonably believe you may be a victim of abuse, neglect, domestic violence, or if disclosure is necessary to prevent a serious threat to health or safety.

CONTACT INFORMATION

Privacy Officer: Derek J Chang DDS
Phone: 361-992-7631

Medical History

Patient Name: _____ **Birth Date:** _____

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.

YES NO Are you under physician's care now? EXPLAIN: _____

YES NO Have you ever been hospitalized or had a major operation? EXPLAIN: _____

YES NO Have you ever had a serious head or neck injury? EXPLAIN: _____

YES NO Are you taking any medications, pills, or drugs? _____

LIST: _____

_____

YES NO Do you take, or have you taken, Phen-Fen or Redux? NAME WHICH: _____

YES NO Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates (used to treat bones)? NAME WHICH: _____

YES NO Are you on a special diet? _____

YES NO Do you use tobacco? If so, how frequently? _____

YES NO Do you use controlled substances or had treatment for drug addiction? EXPLAIN: _____

Women: are you...

☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ List:

Do you use controlled substances? ☐ Yes ☐ No ☐ List: _____

Circle if you have had or have any of the following and please explain:

-Anemia
-Angina
-Arthritis/Gout
-Artificial Heart Valve
-Artificial Joint
-Asthma
-Blood Disease
-Blood Transfusion
-Breathing Problems
-Bruise Easily
-Cancer
-Chemotherapy
-Chest Pains
-Cold Sores/Fever Blisters
-Congenital Heart Disorder
-Convulsions
-Yellow Jaundice
-Cortisone Medicine
-Diabetes
-Drug Addiction
-Easily Winded
-Emphysema
-Epilepsy or Seizures
-Excessive Bleeding
-Excessive Thirst
-Fainting Spells/Dizziness
-Frequent Cough
-Frequent Diarrhea
-Frequent Headaches
-Genital Herpes
-Glaucoma
-Hay Fever
-Heart Attack/Failure
-Heart Murmur
-Heart Pacemaker
-Heart Trouble/Disease
-Acid Reflux
-Hemophilia
-Hepatitis A
-Hepatitis B or C
-Herpes
-High Blood Pressure
-High Cholesterol
-Hives or Rach
-Hypoglycemia
-Irregular Heartbeat
-Kidney Problems
-Leukemia
-Liver Disease
-Low Blood Pressure
-Lung Disease
-Mitral Valve Prolapse
-Osteoporosis
-Pain in Jaw Joints
-Parathyroid Disease
-Psychiatric Care
-Radiation Treatment
-Recent Weight Loss
-Renal Dialysis
-Rheumatic Fever
-Rheumatism
-Scarlet Fever
-Shingles
-Sickle Cell Disease
-Sinus Trouble
-Spina Bifida
-Stomach/Intestinal Disease
-Stroke
-Swelling of Limbs
-Thyroid Disease
-Tonsillitis
-Tuberculosis
-Tumors or Growths
-Ulcers
-Venereal Disease

Have you ever had a serious illness not listed above? If yes, please explain:

Patient (Parent/Guardian) Signature: _____ **Date:** _____