WELCOME

PATIENT INFORMATION

Date ______________________________

SS # ______________________________

Patient Name ______________________________

Preferred Name ______________________________

Address ______________________________

City ______________________________

State ______________ Zip ______________

E-Mail ______________________________

Sex ☐ M ☐ F Age ______________

Birth date ______________________________

☐ Married ☐ Widowed ☐ Minor

☐ Separated ☐ Divorced ☐ Single

☐ Partnered

Occupation ______________________________

Patient Employer/School ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (____) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS# ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

____

DENTAL INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Is Patient covered by additional insurance? Yes No

Secondary Insurance Co. ______________________________

Secondary Group # ______________________________

ASSIGNMENT, RELEASE & FINANCIAL RESPONSIBILITY

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Dr. _____CALVIN I. WHANG DDS______________ all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. All unpaid balances in my and/or my family's account over 90days are subject to a finance charge of 1.5% per month until paid in full. In case suit or action is instituted to collect any amount due, patient promises to pay all collection costs and such additional sums as a court may adjudge reasonable.

The above-named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end upon written notification of departure from this practice.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

PHONE NUMBERS

Home ( ) ______________ Work ( ) ______________ ext _____ Cell Phone ( ) ______________

Spouse's Work ( ) ______________ Best time and place to reach you ______________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name ______________________________ Relationship ______________________________

Home Phone ( ) ______________________________ Work Phone ( ) ______________________________

DENTAL HISTORY

Reason for today's visit ______________________________

Former Dentist ______________________________ City/State ______________________________

Date of last dental visit ______________________________ Date of last dental X-rays ______________________________

CONFIDENTIAL HEALTH HISTORY

Patient Name ______________________________ Date of Birth ____________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain ______________________________
2. Yes No Has there been a change in your health within the last year?
   If YES, explain ______________________________
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain ______________________________
4. Yes No Are you being treated by a physician now? If YES, explain ____________________
   Date of last medical exam ______________ Reason for exam ______________
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain ______________________________
   Date of last dental exam ______________ Name of last treating dentist ______________
6. Yes No Are you in pain now?
   If YES, explain ______________________________

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (please circle all that apply)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent caugh	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (please circle all that apply)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (please circle all that apply)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine, Xylocaine)	Latex	Food
Nitrous Oxide	Erythromycin	Metal

Others ____

____

HEALTH HISTORY (cont'd)

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (please circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicine	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list ____

____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?

If YES, what month? ______________________________

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, pleas explain ______________________________

____

Yes No Have you ever been pre-medicated for dental treatment?

If YES, why ______________________________

Yes No Have you ever taken Fen-Phen? If YES, when ______________________________

Yes No Are there any issues or conditions that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature ______________________________ Date ______________

Physician's Name ______________________________ Phone ______________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

______________	______	______________	______
Signature of Patient (Parent/Guardian)	*Date*	*Signature of Dentist*	*Date*

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from our office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer: Wendy Whang
Office Address: 12705 Monte Vista Rd.
Poway, CA 92064
Phone: (858) 487-8090

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-677

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third-party payers for my health care services.
- ❑ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices***. I understand that my dental provider has the right to change the Notice of Privacy Policies and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: ______________________________ Date: _______________________

Signature: _________________________________

Relation to Patient: __________________________

Dependent family members also covered by this acknowledgement:

___

___

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ❑ The patient refused to sign
- ❑ Communication barriers
- ❑ Emergency situation
- ❑ Other: ____

Photograph Authorization

I hereby give my consent for **Dr. Whang** to take photographs, slides and/or videotape of

______________________________ (patient's name) face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise for the use of these images.

Please Initial

_______ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.

_______ I consent to the use of my photographs, slides, and/or videotape ONLY for laboratory use.

_______ I DO NOT consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

____ ____________________

Parent's or Legal Guardian's/Representative's Signature Date

____ ____________________

Dentist's Signature Date

COPY OF THIS SIGNED DOCUMENT TO BE PLACED IN PATIENT'S CHART

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy.

Regarding Payment

We accept the following forms of payment: Cash, Check, Debit Cards, American Express, Discover, Visa and MasterCard. Returned checks are subject to a $20.00 returned check fee.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the office.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. We will try to give you the best possible estimate of what your policy may cover, but keep in mind that the determinations by your insurance company are not under our control. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Name: ____

Financially Responsible Party:_______________________________ Date:____________