Chicago Dental Group in Everett
Dae Ho Kim DDS

Patient Information

Today's Date _____ Home Phone _____ Cell Phone _____

Name _____ SS/HIC/Patient ID # _____

Address _____ Email _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ yrs

Patient Employer /School _____ Occupation _____

Employer/School Address _____ Employer/School phone _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that the above named Insurance Company(ies) and their agents for the purpose of obtaining payment or services and determining insurance benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent Guardian or Personal Representative — Relationship to Patient

Financial Agreement and Authorization for Treatment

Patient's Name _____

I authorize treatment of the person named above, and I agree to pay the office of Dae Ho Kim DDS all fees and charges for any treatment at the time such treatment is rendered. If an insurance co-payment is due, it will be paid at the time of treatment. Any other financial arrangements will be made only with presentation of reports obtained by this office from credit reporting agencies. All charges shown on a billing statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days after the billing date. In the event legal action should become necessary to collect an unpaid balance due for treatment services rendered to me or to my family, I agree to pay reasonable attorney's fees, court costs, and other costs as the Court determines proper. If my account is sent to collection, I agree that a $50.00 fee will be added to the balance due to be paid by me or my family.

I agree that my payments will not be delayed or withheld because of any insurance coverage or pending insurance claims I may have for the treatment services rendered. I agree that all insurance proceeds are assigned to this office where applicable, but also that this office does not assume responsibility for the collection of insurance proceeds. I understand and agree that there will be assessment on all unpaid balances over 30 days old. An interest charge of 1% per month will be added, and a $35 fee will be charged for any check returned dishonored.

If I fail to come to my appointment, or if I fail to cancel my appointment at least 48 hours in advance of the scheduled appointment time, I agree to pay a broken appointment fee of $50.00 per 1/2 hour of scheduled time. The broken appointment fee must be paid in cash before we will re-schedule you.

Signature _____ Date _____

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Physician's Phone:_____

Date of last visit:_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain:_____

Do you use tobacco in any form? ❑ Yes ❑ No Any history of tobacco use: _____

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No Year: _____

Are you taking any medications? ❑ Yes ❑ No

Please list each one:_____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one:_____

Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Bleeding	❑	❑	Glaucoma	❑	❑	Sickle Cell Disease
❑	❑	Alcohol Abuse	❑	❑	HIV+ AIDS	❑	❑	Sinus Problems
❑	❑	Allergies	❑	❑	Heart Attack	❑	❑	Stroke
❑	❑	Anemia	❑	❑	Heart Murmur	❑	❑	Thyroid Problems
❑	❑	Angina Pectoris	❑	❑	Heart Surgery	❑	❑	Tuberculosis
❑	❑	Arthritis	❑	❑	Hemophilia	❑	❑	Ulcers
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis A			
❑	❑	Asthma	❑	❑	Hepatitis B	Yes	No	Allergies
❑	❑	Blood Transfusion	❑	❑	Hepatitis C	❑	❑	Aspirin
❑	❑	Cancer	❑	❑	High Blood Pressure	❑	❑	Codeine
❑	❑	Chemotherapy	❑	❑	Joint Replacement	❑	❑	Erythromycin
❑	❑	Colitis	❑	❑	Kidney Problems	❑	❑	Latex
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease	❑	❑	Penicillin
❑	❑	Diabetes	❑	❑	Low Blood Pressure	❑	❑	Tetracycline
❑	❑	Difficulty Breathing	❑	❑	Mitral Valve Prolapse	❑	❑	Sulfa
❑	❑	Drug Abuse	❑	❑	Pace Maker	❑	❑	Metal
❑	❑	Emphysema	❑	❑	Psychiatric Problems			
❑	❑	Epilepsy	❑	❑	Radiation Therapy	Other:		
❑	❑	Facial Surgery	❑	❑	Rheumatic Fever			
❑	❑	Fainting Spells	❑	❑	Seizures			
❑	❑	Fever Blisters	❑	❑	Sexually Transmitted Disease			
❑	❑	Frequent Headaches	❑	❑	Shingles			
❑	❑	Stomach/Intestinal disease						

Yes	No	If Female,Please answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks _____
❑	❑	Are you nursing?

Nearest relative not living with you:

Name:_____Relationship:_____

Address:_____Phone:_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____Date:_____

Dentist Signature:_____Date:_____

How may we help you today?_____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning?_____

When was your last dental visit?_____

Why did you leave your previous dentist?_____

How can we accommodate you better during your dental visit?_____

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. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filed; referring you to another doctor or clinic for other health care of services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health

information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions;

participation in manages care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

1. when a state of federal lay mandates that certain health information be reported for a specific purpose;
2. for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
3. disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
4. uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
5. disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
6. disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
7. disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
8. uses or disclosures for health related research;
9. uses and disclosures to prevent a serious threat to health or safety;
10. uses or disclosures for specialized government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
11. disclosures of de-identified information;
12. disclosures relating to worker's compensation programs;
13. disclosures of a "limited data set" for research, public health, or health care operations;
14. incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
15. disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information; Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine

appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written

"authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

1. ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
2. ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
3. ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
4. ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.
5. get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance, We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
6. get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Everett Chicago Dental's Notice of Privacy Practices.

Patient Name _____

Signature_____ Date _____