Thomas Yoon Dental

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Social Security #: _____ Date of Birth: _____/_____/_____ Gender: Male Female Marital status:_____

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

E-mail Address: _____

Address: _____
Street

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following?

	yes	no		yes	no		yes	no		yes	no
AIDS/HIV	O	O	Excessive Bleeding	O	O	Liver Disease	O	O	Stroke	O	O
Allergies:	O	O	Fainting	O	O	Mental Disorders	O	O	Tuberculosis	O	O
_____			Glaucoma	O	O	Nervous Disorders	O	O	Tumors	O	O
Anemia	O	O	Growths	O	O	Pacemaker	O	O	Ulcers	O	O
Arthritis	O	O	Hay Fever	O	O	Currently pregnant	O	O	Venereal Disease	O	O
Artificial Joints	O	O	Head Injuries	O	O	Due date: _____			Codeine Allergy	O	O
Asthma	O	O	Heart Disease	O	O	Radiation Treatment	O	O	Penicillin Allergy	O	O
Blood Disease	O	O	Heart Murmur	O	O	Respiratory Problems	O	O	Osteoporosis	O	O
Cancer	O	O	Hepatitis	O	O	Rheumatic Fever	O	O	OTHER:	O	O
Diabetes	O	O	High Blood Pressure	O	O	Rheumatism	O	O	_____		
Dizziness	O	O	Jaundice	O	O	Sinus Problems	O	O	_____		
Epilepsy	O	O	Kidney Disease	O	O	Stomach Problems	O	O			
Difficulty swallowing	O	O	Smoking	O	O	Interested in whitening	O	O	Popping Jaw	O	O
Difficulty chewing	O	O	____/day, How long ____yr			Interested in nice smile	O	O	Headaches	O	O
Bad Breath	O	O	Sensitive teeth	O	O	Interested in nightguard	O	O	Neck/upper back pain	O	O
Grinding	O	O	Bleeding gums	O	O	History of Braces	O	O	Jaw pain	O	O
Currently own nightguard?	O	O	Clenching	O	O	TMJ problem	O	O	Facial pain	O	O

- Do you have or have you ever had any problem, disease or disease not listed above? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications daily including Aspirins? ☐ Yes ☐ No
  If yes, the name of medicines: _____
- Are you aware of having an allergic reaction to any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

  Name of Physician: _____ Phone #: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____ _____ _____
Signature of patient, parent or guardian **Date** **Initial of Provider** **Date**

Referral Information

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Insurance Directory

☐ Another patient, friend ☐ Another patient, relative

Name of person or office referring you to our practice:_____

☐ Other: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Cell): _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Dental Insurance

Insurance company and Plan Name_____

Insurance ID #: _____ Group # _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Dental Insurance

Insurance company and Plan Name_____

Insurance ID #: _____ Group # _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services & Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Also this office will collect the difference between covered procedures and down-graded procedures when the service is done for the patient who has an alternate benefit upon patient agreement.

A service charge of **1½% per month (18% annually)** on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In the event collection proceedings are instituted to enforce payment of fees, you are responsible for any attorney fees and associated court cost necessary for collection. There is a **$35.00 dollar** fee for all **returned checks**.

Appointments are scheduled on an individual basis, reflecting the amount of time needed to complete specific treatment. We do, however, realize that everyone has busy schedules. If you need to change or cancel an appointment, we ask that you call us no later than **48 hours in advance**, so that this time may be used for other patients in need. Failure to do so will result in **$50.00 dollars per 30 minutes or $150 for appointments longer than 1 hour** charge for the **appointment missed**.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

THOMAS YOON DENTAL

Jangyeul Yoon D.D.S. PC

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, 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 authorized 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 $10.00 for each page or $30.00 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.

Thomas Yoon Dental

Jangyeul Yoon DDS

10807 Main Street Suite 200

Fairfax, VA 22030

Phone: 703) 261- 6999

Fax: 703) 349- 2575

Thomas Yoon Dental

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practice tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

Signature: _____ Date: _____
(Patient or Legal Representative)

CONSENT:

I consent to the use and sharing of my health records for my treatment, payment from insurance companies, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you can not provide services to me.

Signature: _____ Date: _____
(Patient or Legal Representative)