JOYCE KAHNG DDS
Family and Cosmetic Dentist

PATIENT REGISTRATION FORM

Patient's Name: _____SSN #: _____

Date of Birth: _____ ☐ Male ☐ Female

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Driver Lic#: _____

Marital Status: ☐ Single ☐ Married Divorced ☐ Widowed

Employer/School Name: _____ Occupation: _____

How did you hear about us? _____

Dental Insurance Information

Insurance Company Name: _____ Phone: _____

Subscriber ID#: _____ Group ID#: _____

Subscriber's Name: _____ SSN#: _____

Date of Birth: _____ Employer: _____ Phone: _____

Insurance and financial policy

Total payment is due at the time of service. We accept Cash, Check, Visa, Master Card, Discover, American Express. We also offer 12 month interest free financing through Care Credit. We are in network with many PPO plans; however your insurance policy is a contract between you, your employer and the insurance company. We are not a part of that contract except to accept the insurance company fees. In the event we do not receive payment from your insurance company within 90 days of filing a claim with them, the balance will be your responsibility. You are ultimately responsible for any services not paid for by your insurance company. Your treatment plan is individually tailored to your dental needs and is not based on your dental insurance benefits and what the y may or may not deem as necessary. In order to give you an estimate of cost for your needed dental treatment, we will verify your insurance benefits prior to treatment but they will only give us a basic breakdown of benefits. It is your responsibility to fully understand the coverage and exceptions of your particular policy.

Consent for Dental Treatment

I hereby give Dr. Joyce Kahng my consent for dental treatment. I have read and fully understand the above stated policies and I agree to abide by them. I grant permission to you and your assignee, to telephone me at any phone number above to discuss matters related to this form and to my dental treatment. By signing this form, I further authorize the release of information to my insurance provider.

Patient

Signature: _____ **Date:** _____

Appointment Change and Cancellation Policy

We make every effort to schedule your treatment at a convenient time. When your dental needs are diagnosed, they need to be addressed in a timely fashion, if left untreated, the condition (s) will worsen. Therefore, it is very important that you keep your appointment as scheduled. Most of our patients are very understanding of how short notice appointment changes affect our ability to deliver care to other patients of our practice.

This dental practice is committed to improving your oral health. We must have a 48-hour notice if you need to make appointment changes. Our policy concerning cancelled or missed appointments is as follows:

A patient must call at least 48 hours in advance when canceling or rescheduling their appointment time.

After a second cancellation or missed appointment we will charge a no show/cancellation fee of $50.00 per appointment.

I, _____ (print name of responsible party). Understand the terms and conditions of this policy.

Signature_____

Date _____

Patient Health History Form

Patient Name_____ Date Today_____

Physician Name _____Physician Phone Number_____

Please check if you have any of the following problems:

□ AIDS / HIV Positive □ Alzheimer's Disease □ Anemia □ Arthritis/Gout □ Artificial heart valves □ Artificial joints □ Asthma Controlled (Y/N) Hospitalized (Y/N) Do you carry an Inhaler? (Y/N) Triggered by: _____ Date of last attack: _____ □ Blood disease □ Blood transfusion □ Cancer Radiation (Y/N) Chemotherapy (Y/N) Location _____ □ Chest pain (Angina) □ Congenital Heart Disorder □ Cold Sores □ Circulation problems	□ Cortisone treatments □ Diabetes (Circle) Type 1 Type 2 Do you Monitor your Blood Sugar (Y/N) □ Emphysema □ Epilepsy or Seizures □ Fainting/Dizziness □ Frequent Cough □ Frequent Headaches □ Genital Herpes □ Glaucoma □ Heart murmur □ History of Heart Attack □ History of Stroke ○ Date_____ □ Heart, any problems □ Hemophilia □ Herpes □ Hepatitis A B C □ High Blood Pressure □ High Cholesterol	□ Kidney disease Renal Dialysis (Y/N) □ Leukemia □ Liver disease Jaundice (Y/N) □ Low Blood Pressure □ Lung Disease □ Mitral valve prolapse □ Osteoporosis □ Pacemaker □ Psychiatric care □ Rheumatic fever □ Scarlet Fever □ Shingles □ Shortness of breath □ Sickle Cell Disease □ Sinus Trouble □ Stomach Ulcers/Disease □ Thyroid problems Hypothyroid Hyperthyroid □ Tonsillitis □ Tuberculosis □ Tumors or Growths □ Venereal Disease

Known Allergies: □ Local anesthetic □ Aspirin □ Penicillin □ Codeine □ Sulfa □ Iodine □ Latex □Other:_____	**List any medications you are currently taking:** _____ _____ **Women:** Pregnant/Trying to be pregnant/Nursing? _____ **All:** If Yes, which medication? (Y/N) Pre-medication required? _____ (Y/N) Are you on Blood Thinners? _____ (Y/N) Drug Abuse (Y/N) Alcohol Addiction (Y/N) Tobacco Use

Dental Health History Form

Name of previous dentist and location:_____

Date of last dental examination and cleaning:_____

Check if you have had any problems with the following:

□ Bad breath	□ Periodontal Disease
□ Bleeding, sensitive gums	□ Sensitivity to cold
□ Clicking or popping jaw: right or left	□ Sensitivity to hot
□ Food trapped between teeth	□ Sensitivity to sweets
□ Grinding or clenching teeth	□ Sensitivity to biting
□ Jaw Pain	□ Sores in mouth
□ Loose teeth	□ Staining
□ Broken fillings	□ Snoring

- Are you Happy with your Smile? Y/N
- Are any of your teeth in pain today? Y/N
- Do you have fears going to the dentist? Y/N
- Have you ever had a deep cleaning? Y/N
- How often do you brush your teeth? _____
- Do you use an Electric Toothbrush or Manual Toothbrush? _____
- How often do you change your toothbrush? _____
- How often do you floss your teeth? _____

Authorization:
I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor:_____

Reviewed by:_____

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 (protected 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. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your 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 purposes 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. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist
in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by
law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in
order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 or at alternative locations.
- 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.

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 this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & 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:
Dr. Joyce Kahng, Dental Director
Joyce Kahng DDS
1831 Orange Avenue, Ste D
Costa Mesa, CA 92627
Ph #: (949)642-0608

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
877-696-6775 (toll-free)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Joyce Kahng DDS
1831 Orange Avenue, Ste D
Costa Mesa, CA 92627
(949)642-0608

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 health care 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 Practices* 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 then you are bound to abide by such restrictions.

Patient Name: _____ **Date**:_____

Signature:_____

Relationship 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

Photography Model Release (Optional)

I, the undersigned, do hereby assign to Dr. Joyce Kahng absolutely the copyright and/or right to copyright such photographs taken throughout my treatment, including before and after photos. I hereby allow the right of reproduction thereof for use by Dr. Joyce Kahng in the use of patient education, case publishing in professional journals, lectures, and websites. As well as practice marketing; including print media, website in any manner, including the right of necessary retouching and tinting or work up for reproduction purposes. I understand that I have voluntarily allowed my photograph to be made, and that I will receive no payment for posing or for allowing my photographs to be reproduced. I hereby waive any right to approve the finished photograph, or any copy, which might be used in conjunction with the finished photograph.

Name:_____

Signature:_____

Date:_____