WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒
13. Have you had any head, neck or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plate or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

B Medical History

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____		
Address _____		
Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness?	❒	❒
Please explain. _____		
_____		
7. Are you taking any medicine(s) including non-prescription medicine?	❒	❒
If yes, what medicine(s) are you taking? _____		
_____		
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion?	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒
Women Only:		
1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Other?_____	☐	☐
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath after mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐
10. Stroke?	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Hives or skin rash?	☐	☐
15. Fainting spells or seizures?	☐	☐
16. Diabetes?	☐	☐
17. AIDS or HIV infection?	☐	☐
18. Thyroid problems?	☐	☐
19. Allergies?	☐	☐
20. Arthritis or rheumatism?	☐	☐
21. Joint replacement or implant?	☐	☐
22. Stomach ulcer?	☐	☐
23. Kidney trouble?	☐	☐
24. Tuberculosis?	☐	☐
25. Persistent cough?	☐	☐
26. Cough that produces blood?	☐	☐
27. Cancer?	☐	☐
28. Sexually transmitted disease?	☐	☐
29. Epilepsy?	☐	☐
30. Anemia?	☐	☐
31. Leukemia?	☐	☐
32. Glaucoma?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

Patient Screening Form

PATIENT NAME:
DATE:

QUESTIONNAIRE	PRE-APPOINTMENT	IN-OFFICE
Do you have a fever or have you/they felt hot or feverish recently (14-21 days)?	□ Yes □ No	□ Yes □ No
Have you have had any flu-like symptoms recently (14-21 days)? ● Cough ● Shortness of breath ● Fever ● Chills ● Repeated shaking ● Diarrhea ● Vomiting ● Muscle ache ● Headache ● Sore throat ● Loss of taste/smell ● Malaise ● Nausea ● Fatigue	□ Yes □ No	□ Yes □ No
Are you having shortness of breath or other difficulties breathing?	□ Yes □ No	□ Yes □ No
Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	□ Yes □ No	□ Yes □ No
Are you experienced recent loss of taste or smell?	□ Yes □ No	□ Yes □ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	□ Yes □ No	□ Yes □ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	□ Yes □ No	□ Yes □ No
Are you awaiting results of a lab test for COVID-19?	□ Yes □ No	□ Yes □ No
Have you tested positive for COVID-19? If so, when?	□ Yes □ No	□ Yes □ No
Have you or a family member previously been asked to self-isolate/self-quarantine recently (14-21 days)?	□ Yes □ No	□ Yes □ No
Have you had close contact with an individual diagnosed with COVID-19 infection recently (14-21 days)?	□ Yes □ No	□ Yes □ No

Yes responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment. Please call to inform us at (714) 827-0206.

Scheduling/Failed Appointments

In continuing our commitment to you and your oral health we are pleased to reserve appointment times that are convenient for you and your family's schedule. In order to provide all patients with times that are convenient for their schedules and to effectively run our dental office, we must maintain those reserved scheduled times. We will be happy to assist you with rescheduling appointments with at least 24 hour notice of change or cancellation.

We do understand things come up, schedules change and illnesses happen and we will handle each case of missed appointments on an individual basis. **We do however reserve the right to charge for missed appointments of $25.00 for cleaning appointments and $50.00 for appointments reserved with Dr. Hong and associates.** Thank you for your efforts on maintaining your reserved dental time, we hope in return this will allow us to schedule your appointments at times that are convenient for you and your family. **Please give 24 hour notice to cancel or change any appointments.** **Initials**_____

Appointment Reminders

We are happy to offer a couple of options to confirm your dental appointments. We are excited to offer text message and e mails. Reminder cards will be mailed three weeks prior to any scheduled continuing care appointment. As a courtesy we can also call to confirm your appointments one day prior to with the exception of weekends and holidays.

Financial Policy . **Initials**_____

Commercial Insurance

We will gladly accept and file any insurance plan. Insurance benefits are determined by the insurance company and the employer. Please refer to your benefits policy for explanations on co-pays, deductibles and for excluded treatment. As a courtesy to our patients we will file your insurance for you for the treatment provided. We are providers for most PPO plans and are paid at in network rates. All other insurance plans will be filed as out of network. Please review your policy to determine the difference in out of pocket expenses when visiting an out of network provider. . **Initials**_____

Co-Pays

We ask that you pay all co-pays in office the day of your treatment. We accept Cash, Check, Visa, Mastercard, Discover, American Express and Care Credit for those payments. Co-pays are only an estimate of the difference between your total treatment and what the insurance company will cover for you. We try to maintain accurate records of those co-pays however since they are only an estimate there may be a balance due after insurance payment. **Initials**_____

I have had the opportunity to ask questions and receive answers for all the questions about my insurance and dental practice policies.

Print name:_____

Patient's or Patient's Representative's Signature:_____

Date:_____

JJ Family Dental

JooYoung Hong D.D.S.

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. This notice is effective as of April 14, 2003.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other health care professionals within our practice or outside practices for the purpose of treatment, payment or health care operations.

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medial condition or in the event of an emergency or of your death.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding,

Law Enforcement: We may disclose your health information to a law enforcement official for identifying or locating a suspect, fugitive, material witness or mission person, complying with a court order or subpoena, and other law purposes.

Marketing: We may contact you for marketing purposes such as sending you newsletter or other information to you by mail, or contacting you to remind you of your appointment time via telephone, mail, or email. If you are not at home, we may leave you a message on your answering machine or with the person who answers phone.

Change of Ownership: In the event that this practice is sold or merged with another organization, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Changes to this Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We will make the new policy available to our patients.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information or to amend your protected health information. Please be advised, however, that this practice is not required to agree to your request. We will let you know if we can fulfill your request.
- You have the right to inspect, receive, or transfer copies of your health information. With a written request and 48 hour notice we will mail your files to you. We may charge a reasonable fee for this service.
- You have the right to a paper copy of this Notice of Privacy Practices at anytime upon request.

Complaints: Complaints about your privacy rights or how this practice has handled your health information should be directed to our Privacy Officer by calling our practice. If you are not satisfied with the manner in which this practice handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave, S.W. Room 509F HHH Building Washington, DC 20201

Acknowledgment

I have read the Privacy Notice and understand my rights contained in this notice.

Patient's Name: _____

Patient's Signature: _____ Date: _____