4th & Morris Dentistry

344 Morris Avenue South • Renton WA 98057
425.226.6227 or 425.255.3576
Dr. Jiyon Kim and Dr. Sang C. Kim

Patient Registration

Name_____ Address_____

City_____ Zip_____ Home# _____Cell# _____Work# _____

Sex ___**F** ___**M** Marital Status **S M D** Birth date _____ **SS#**_____-_____-_____
(Circle one) **(Only needed if used as insurance ID#)**

Email address _____

Patient Employed by_____ Business Address_____

In case of emergency notify, _____ Phone_____
(Name and relationship)

Whom may we thank for referring you? _____

Dental Insurance

Primary	Secondary
SUBSCRIBERS'S NAME	SUBSCRIBERS'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SUBSCRIBER #	SUBSCRIBER #
GROUP #	GROUP #
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION

Dental History

Previous Dentist _____

Address _____(_____) _____
Number Street City State Zip Telephone

Date of last dental visit_____ Date of last dental x-rays _____ Reason for leaving _____

Are your teeth affecting your general health?	YES NO	Have you experienced prolonged bleeding or slow			
Are you satisfied with your teeth and gums?	YES NO	healing after a tooth extraction?	YES NO		
Do you have sore or sensitive teeth?	YES NO	Have you had orthodontic treatment (braces)?	YES NO		
Have you ever been treated for periodontal disease?	YES NO	Are you aware of grinding or clenching your teeth day or night?	YES NO		
Have you ever had serious complications with dental treatment?	YES NO	Have you neglected regular dental visits in the past?	YES NO		
Do you want your teeth to be whiter?	YES NO	Are you dissatisfied with the appearance of your teeth?	YES NO		

How often do you brush? _____How often do you floss? _____ **Tell us about your dental health**: _____

_____

Medical History

Physician Name: _____ Phone: _____ Date of last health care exam: ____/____/____

What was the exam for? _____ Have you been hospitalized in the last 5 years? (Please circle) **NO YES**

If yes, reason: _____

Medications:

Are you taking blood thinners such as aspirin or coumadin? _____

Are you currently taking any medications, prescription or over the counter drugs? (Please circle) **NO YES** If yes, please list: _____

_____

Are you required to Pre-medicate before dental treatment? (Circle) **NO YES** if yes, reason _____

Are you a smoker? (Circle) **NO YES** If so, how much per day and for how long? _____

Are you taking or have you ever taken fosomax or any biophosphonate related drugs? (Circle) **NO YES**

Please check any of the following which you have now or have had in the past. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked questions concerning your response.

__HIV infection/AIDS
__ HIV positive/AIDS
__Anemia
__Blood Transfusion
__Headaches
__Artificial joints
__Asthma
__Back problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cough, Persistent
__ Cosmetic Surgery
__ Fainting
__ Artificial heart valves
__Glaucoma
__Radiation Therapy
__Heart Attack
__Heart Murmur
__Heart Problems
Describe: _____
__Hemophilia
__Diabetes
__High/low Blood Pressure
__Liver Disease (Jaundice)
__ Emphysema
__ Heart Pacemaker
__ Bruise Easily
__Psychiatric Care
__Sickle Cell Disease
__Respiratory Disease
__Rheumatic/Scarlet Fever
__ Shingles
__Shortness of Breath
__Swelling, feet/ankle
__Hepatitis (type) _____
__Tobacco Habit
__ Fever Blisters/Cold Sores
__ Seizures
__ Arthritis/Rheumatism
__Venereal Disease
__ Anxiety Disorder
__ Lupus
__Epilepsy
__Mitral Valve Prolapse
__Kidney Disease
__ Stomach Ulcers
__Thyroid Problem
__Tuberculosis

Is there anything else you would like us to be aware of? _____

Are you being treated for any illness now? (Circle) **NO YES** if yes, please explain: _____

_____

Please list any allergies you have: _____

Women: Are you pregnant? **NO YES**
If no, are you planning a pregnancy in the near future? **NO YES**
Are you nursing? **NO YES**
Are you taking birth control pills? **NO YES** if yes, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the dentist of any changes in my health or medications.

Patient's Signature: _____ **Date**: _____/_____/_____

Financial Policy Agreement
Optional Payment Terms:

1. **2 Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the balance due at the second appointment.
2. **Discount Plans:** Patients on the AmeriPlan or Carington dental plans will not receive any additional discounts.
3. **Care Credit**: We offer our patients, upon approval, a financing program with no down payment, several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application.

Payments are due at the time services are rendered.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. We accept cash, checks, ATM cards, and all major credit cards.

Please read and acknowledge our Notice of Privacy Practices attached

• Acknowledgement of Privacy Practices

4th & Morris Dentistry ~ Renton, WA

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 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*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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:

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)

OTHER-SPECIFY Names Signatures ID

____

____

____

____

_ _

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

NOTICE OF PRIVACY PRACTICES
4th & Morris Dentistry 344 Morris Avenue S Renton, WA 98057

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 cornered entities that misuse personal health information. As required by HIPAA, we have prepared the 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 to one or more health care providers. For example, we may need to share your information with other providers or specialist involved in the communication 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 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 require 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 heath 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 request 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 rights to access, inspect and copy your protected health information.
- The right to request an amendment to you 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 your 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 Notices 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 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 or 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:
complaint:

4th & Morris Dentistry
344 Morris Avenue S
Renton, WA 98057
425.226.6227

For more information about HIPAA or to file a

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
877.696.6775

4th & Morris Dentistry
Financial Policy
Effective January 2nd 2014

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve, which allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

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2. Discount Plans: Patients on the AmeriPlan or Careington dental plans will **NOT receive any additional discounts.**

3. Care Credit: We offer our patients, upon approval, a financing program with no down payment, several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application.

4. Any other options will need to be discussed with the front office staff.

PATIENTS ARE ENTITLED TO ONLY ONE DISCOUNT.

Payments are due at the time services are rendered.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. We accept cash, checks, ATM cards, and all major credit cards.