{Jong K. Byun D.D.S. PLLC}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Dr. Jong K. Byun
114 W. Main Street
P.O. Box 219
Yadkinville, NC 27055

Payment Policy and Appointment Agreement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. **If you have dental insurance, we are happy to help you receive your maximum allowable benefits.** In order to achieve these goals we need your understanding of our payment policy. For the convenience of our patients, we offer the following methods of payment of fees:

1. Payment in full by cash, check, Visa or MasterCard is expected at **each visit**.
2. We gladly accept insurance assignment, but require that the **deductible** and **percentage** of non-covered fees, be paid as services are rendered. In the event of duplicate payment, you will be reimbursed.
3. For crowns, bridges, root canals, partials, dentures, appliances and bleach trays, ½ of the total is due at the initial visit when impressions are taken and before they are sent to the lab. The balance is expected upon completion of the procedure.

IT IS IMPORTANT TO REALIZE; HOWEVER, THAT:

A. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. **This office files your insurance as a courtesy to you.**
B. Fees are subject to change without notice prior to starting treatment.
C. Not all dental services are a covered benefit in all contracts.
D. **You** (not your insurance company) are responsible to us for all fees for services rendered to you.
E. A pre-treatment estimate will be provided upon request. This may require x-rays and take 4-6 weeks for response of benefits.

Please be aware that any person bringing a child to our office is legally responsible for payment of all services rendered on behalf of that child.

There will be a $25.00 fee per appointment after three broken appointments.

_____ _____

Signature of Person Financially Responsible Date

Jong K. Byun D.D.S. PLLC

Consent For Use And Disclosure Of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of privacy practices: You have the right to read our Notice Of Privacy Practices before you sign this consent. Our notice provides a description of our payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I understand that, by signing this consent form, I am giving my consent for use and disclosure of protected health information to carry out treatment, payment activities and health care operations with referring offices and insurance providers..

I consent that you can leave detailed phone messages on an answering machine and discuss protected health information with the following people.

_____, _____

_____, _____

By signing I authorize the release of protected health information.

Signature: _____ Date: _____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation.

If this consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representative's Name: _____

Relationship to Patient: _____

You may obtain a copy of our Notice of Privacy Practices by contacting our office at 336-679-2181

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____

Home Phone (___) _____ Cell Phone (___) _____

City_____ State _____ Zip _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner

❑ Divorced ❑ Widowed ❑ Separated

Employer _____Business Phone (___) _____

Business Address _____ Occupation _____

Who should we thank for referring you?_____

In case of emergency, who should we contact?_____

Phone (___) _____

Notes: _____

_____

_____

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums ..... Yes No
Unpleasant taste/bad breath ..... Yes No
Burning tongue/lips ..... Yes No
Frequent blisters, lips/mouth ..... Yes No
Swelling/lumps in mouth ..... Yes No
Ortho treatments (braces) ..... Yes No
Biting cheeks/lips ..... Yes No
Clicking/popping jaw ..... Yes No
Difficulty opening or closing jaw ..... Yes No

TEETH

Loose teeth ..... Yes No
Sensitive to hot ..... Yes No
Sensitive to cold ..... Yes No
Sensitive to sweets ..... Yes No
Sensitive to biting ..... Yes No
Food impaction ..... Yes No
Clenching/grinding ..... Yes No
If so, when _____
Shifting in bite ..... Yes No
Change in bite ..... Yes No

8. Do you use the following?
   Brush ..... Yes No
   Dental floss ..... Yes No
   Fluoride rinse ..... Yes No
   Other _____

MEDICAL

1. Has there been any change in your general health within the past year ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years ..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease ..... Yes No
   b. Congenital heart disease ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... Yes No
      1) Do you have pain in chest upon exertion ..... Yes No
      2) Are you ever short of breath after mild exercise ..... Yes No
      3) Do your ankles swell ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... Yes No
   d. Artificial or replacement valves ..... Yes No
   e. Pacemaker ..... Yes No
   f. Allergy ..... Yes No
   g. Sinus trouble ..... Yes No
   h. Asthma or hay fever ..... Yes No
   i. Hives or a skin rash ..... Yes No
   j. Fainting spells or seizures ..... Yes No
   k. Diabetes ..... Yes No
      1) Do you have to urinate (pass water) more than six times a day ..... Yes No
      2) Are you thirsty much of the time ..... Yes No
      3) Does your mouth frequently become dry ..... Yes No

l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other _____ Yes No

8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... Yes No
   a. Do you bruise easily ..... Yes No
   b. Have you ever required a blood transfusion ..... Yes No
      If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus ..... Yes No
10. Do you have any blood disorder such as anemia ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition ..... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs ..... Yes No
   b. Anticoagulants (blood thinners) ..... Yes No
   c. Medicine for high blood pressure ..... Yes No
   d. Cortisone (steroids) ..... Yes No
   e. Tranquilizers ..... Yes No
   f. Antihistamines ..... Yes No
   g. Aspirin ..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
   i. Digitalis or drugs for heart trouble ..... Yes No
   j. Nitroglycerin ..... Yes No
   k. Other medications _____ Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics Yes No
   h. Other _____ Yes No
14. Do you use any tobacco products ..... Yes No
   If so, how much per day and what _____
15. Do you use any alcohol products ..... Yes No
   If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
   If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about ..... Yes No
   If so, explain _____
   _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
19. Are you wearing contact lenses ..... Yes No
20. Are you experiencing stress or pressure in your work or at home ..... Yes No

WOMEN

21. Are you pregnant ..... Yes No
22. Do you have PMS or problems associated with your menstrual period ..... Yes No
23. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date