JAMES KIM, D.D.S.

Last Name	First Name	Initial	Date of Birth
Address Street	Apt. # City	State Zip	Home Phone
Drivers License #	Social Security No.		Sex M ☐ F ☐
Employer	Position	Business Phone	Cell Phone
E-mail address:	Spouse / Partner's Name:		

FINANCIALLY RESPONSIBLE PARTY, IF A MINOR

Name	Address	Home # Work #
Driver's License #	SS # & Date of Birth	Employer

INSURANCE INFORMATION

Name and Phone # of dental plan	Subscriber's name	Subscriber's SS# or ID# & Date of Birth

IN CASE OF EMERGENCY CONTACT NAME _____ **PHONE** _____

WHOM MAY WE THANK FOR REFERRING YOU?: _____

MEDICAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING

	Yes	No
Hepatitis or Liver Disease		
Epilepsy, Convulsions or Seizures		
Rheumatic Fever		
Kidney or Bladder Disease		
Diabetes		
Tuberculosis or Emphysema		
Lung/Pulmonary Disease		
Heart Disease		
Heart Murmur		
High/Low Blood Pressure		
HIV+/AIDS		
Cancer		
Chemotherapy/Radiation Therapy		
Stroke		
Thyroid Trouble		
Sleep Apnea		
Asthma		
Anemia		
Arthritis		
Osteoporosis		
Prosthetic Devices:		
Heart Valve		
Hip / Knee		
Other		
Allergies		
An unfavorable reaction to a drug		
Such as: Aspirin		
Codeine		
Penicillin		
Any Others		
Surgery within the last 5 years		

_____

_____

_____

Weight: _____ Height: _____

Date of last Physician visit: _____

Date of last Dental visit: _____

	Yes	No
Do you clench your teeth day or night?		
Do you have prolonged bleeding following injury or tooth extraction?		

Illness not listed _____

_____

_____

LIST MEDICATIONS CURRENTLY TAKING INCLUDING OVER THE COUNTER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental Concerns if any:

_____

_____

_____

_____

_____

_____

	Yes	No
Have any fear of dental treatment		
Want to keep your teeth		
yes, no matter how much trouble		
yes, if it's not too much trouble		
not sure		
IF FEMALE, ARE YOU NOW:		
Pregnant		
Taking birth control pills		
Through menopause		
Taking hormone medication		
Taking osteoporosis medication		

_____

_____

_____

_____

_____

CANCELATION POLICY

We reserve the right to charge a fee of $50.00 for appointments missed with less than 24 hours notice.

Please call with questions or concerns.

I have read and answered all the Medical and Dental questions to the best of my knowledge and I acknowledge that I am financially responsible for fees incured on services provided.

_____ _____ _____

DATE PATIENT SIGNATURE IF MINOR, GUARDIAN OR PARENT SIGNATURE

_____ _____

DATE DENTIST SIGNATURE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

JAMES KIM, D.D.S
12129 N FM 620, SUITE 300
AUSTIN, TEXAS 78750
(512)249-9147

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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. I also understand 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: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

James Kim, D.D.S

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") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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 "HIPPA", 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include teeth cleaning services.

Payments means such activities as obtaining reimbursement for services, coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, costmanagement analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

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

NOTICE OF PRIVACY PRACTICES

This **Notice of Privacy Practices** describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HALTH INFORMATION. When we give you our Notice of Privacy Practices, you will be asked to sign an Acknowledgement of Receipt. Once you have received our Notice and singed the Acknowledgement, we will use you protected health information for treatment, payment and health care operations. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgment of Receipt as soon as reasonably practicable after the delivery of treatment. The following examples show the types of uses and disclosures of your protected health information that our office is permitted to make:

TREATMENT: Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your dental care. We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

PAYMENT: Your protected health information may be used and disclosed to pay your health care bills. Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

HEALTHCARE OPERATIONS: We may use or disclose your protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and conducting auditing or review activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sing your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may send your reminder postcards or telephone you to remind you of an appointment. We

may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Office to request that these materials not be sent to you.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION. Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

USE AND DISCLOSURE PERMITTED WITHOUT AUTHORIZATION BUT WITH OPPORTUNITY TO OBJECT.

FAMILY MEMBERS AND FRIENDS: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

OTHER DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION.

REQUIRED BY LAW: We may use or disclose your protected health information when we are required do so by law.

MILITARY PERSONNNEL AND NATIONAL SECURITY: We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities.

YOU HAVE THE FOLLOWING RIGHTS:

TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION: 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 practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending a letter to our Privacy Office listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare summary or an explanation of your healthcare information for a fee.

TO RECEIVE AN ACCOUNTING OF DISCLOSURES WE HAVE MADE OF YOUR HEALTH INFORMATION: You have the right to an accounting of disclosures of your health information

that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee.

TO OBTAIN A PAPER COPY OF THIS NOTCE FROM US: You have the right to obtain a paper copy of this Notice upon request, even if you have agreed to accept this Notice electronically.

PRIVACY OFFICER: James J. Kim, DDS

ADDRESS: 12129 N FM 620, Suite 300 Austin, TX 78750

PHONE: 512_249-9147