

Rainier Ave. Dental
5425 Rainier Ave S., Seattle, WA 98118 **206-725-3667**
Dr. Jiyon Kim and Dr. Sang C. Kim

Health History Update

Name _____

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: _____

Emergency Contact Name: _____

Relationship: _____

Phone Number: _____

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.

<input type="checkbox"/> HIV infection/AIDS	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Fever Blisters/Cold Sores
<input type="checkbox"/> HIV positive/AIDS	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Headaches	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Anxiety Disorder
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic/Scarlet Fever	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Back problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Blood Disease	Describe: _____	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Swelling, feet/ankle	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis (type) _____	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High/low Blood Pressure	<input type="checkbox"/> Tobacco Habit	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Liver Disease (Jaundice)		
<input type="checkbox"/> Cough, Persistent			

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. **Cash Payment in Full:** We offer a 10% book keeping discount
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.

Acknowledgment Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Rainier Ave Dental Privacy Practices,
(Print Name)
Financial Policy and I authorize the assignment and release form.

Patient's Signature

Date

If patient is a minor: Parent/Guardian'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.

• Acknowledgement of Privacy Practices

Rainier Ave Dental- Seattle, 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

Rainier Avenue Dental ~ Seattle, WA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE
USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE
REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your

care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please Contact:

**Rainier Avenue Dental
Seattle, WA
206-725-3667**

If we cannot resolve your complaint you have the right to file a complaint with the Secretary of the department of Health & Human Services (HHS) Office for Civil Rights, 2201 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will You be penalized for filing a complaint.