

Justin P. Wong, D.D.S., P.C.

PATIENT'S NAME _____
Last _____ First _____ Initial _____

IF CHILD:
PARENT'S NAME _____
Last _____ First _____ Initial _____

HOW DO YOU WISH
TO BE ADDRESSED _____

Single Married Separated Divorced Widowed Minor

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

CELL PHONE: _____

BUSINESS PHONE: _____

HOME PHONE: _____

EMAIL: _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT: Insurance Credit Card Cash

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY
NOT LIVING WITH YOU _____

Date _____ Date of Birth _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

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 | |
| Dental floss..... | |
| Fluoride rinse | |
| 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.....
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
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years
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
 - b. Congenital heart disease
 - c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)
 - 1) Do you have pain in chest upon exertion
 - 2) Are you ever short of breath after mild exercise
 - 3) Do your ankles swell
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep.....
 - d. Artificial or replacement valves.....
 - e. Pacemaker
 - f. Allergy
 - g. Sinus trouble
 - h. Asthma or hay fever
 - i. Hives or a skin rash.....
 - j. Fainting spells or seizures.....
 - k. Diabetes
 - 1) Do you have to urinate (pass water) more than six times a day.....
 - 2) Are you thirsty much of the time
 - 3) Does your mouth frequently become dry.....

i. 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.

**Justin P Wong DDS PC
5639 E 5th St, Ste C
Tucson, AZ 85711**

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

The Privacy of your Health Information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/01/2003 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations, For Example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

PAYMENT: we may use and disclose you health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorizaiton while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

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

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with an appointment reminders (such as voicemail messages, postcards, texts, or letters)

PATIENT RIGHTS

ACCESS: 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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies or staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$45 per hour for staff time to locate and copy your health information, and postage if you want the copied mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. 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 these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

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.

ELECTRONIC NOTICE: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Judy Lee or Crissy Baselice

Telephone: 520-745-0223 Fax: 520-745-2419 E-mail: info@justinwongdds.com

Address: 5639 E 5th Street, Ste C; Tucson, AZ 85711

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This Form is educational only, does not constitute legal advice and covers only federal, not state law in effect as of 3/27/2002.

Justin P Wong DDS PC
5639 E 5th St, Ste C
Tucson, AZ 85711

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.
Please Print Name

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) _____

**Justin P Wong DDS PC
5639 E 5th St, Ste C
Tucson, AZ 85711**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: Home _____ Cell _____ E-mail: _____

Social Security Number: _____

Section B: To the Patient: PLEASE READ CAREFULLY the following Statements:

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 decide whether to sign this Consent. Our Notice provides a description of our treatment, 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Persons: Judy Lee or Crissy Baseline

Telephone: 520-745-0223 Fax: 520-745-2419 E-mail: info@justinwongdds.com

Address: 5639 E 5th St, Ste C; Tucson, AZ 85711

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Signature: X _____

Date: _____

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

Personal Representative Name: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.