GETTING TO KNOW OUR PATIENT

Welcome to our dental family! We are so happy to be your dentist! Please fill out this form to the best of your ability. This completed form will help us to better serve you. We appreciate your cooperation and help!

Date: _____

PATIENT INFORMATION

Patient Name (First / Middle Initial / Last): _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Home Address: _____ City, State, ZIP _____

Email Address: _____ Marital Status: Single /Married/Divorced/Separated

Driver License #: _____ Issuing State: _____

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Insurance ID #: _____ Social Security Number: _____-_____-_____

Dental Primary Insurance Company: _____ Group: _____

Dental Secondary Insurance Company: _____ Group: _____

RESPONSIBLE PARTY

Patient Name (First / Middle Initial / Last): _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Home Address: _____ City, State, ZIP _____

Insurance ID #: _____ Marital Status: Single /Married/Divorced/Separated

Driver License #: _____ Issuing State: _____ Relationship to Patient: _____

Responsible Party's Employer: _____ Occupation: _____

Business Address: _____ City, State, ZIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Choose only one.)

___ Referred by a Friend ___ Referred by Spouse ___ Referred by Employer/Insurance Plan ___ Google

___ Online Reviews ____ Yelp ___ Website ___ Social Media ___ Sign by Building ___ Direct Mailing

___ Newspaper Ad ___ Creative Smiles Employee ___ Dental Specialist ___ Other

_____ _____ _____

Signature Date Relationship to Patient

HEALTH HISTORY

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions don't hesitate to ask. Thank you, Drs. Jeannie and Sung Ju.

Patient Name: _____ Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam? _____ Date of last dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	42.	Yes	No	Tumors, cancer?
30.	Yes	No	Heart attack, heart defects?	43.	Yes	No	Radiation therapy?
31.	Yes	No	Heart murmurs?	44.	Yes	No	Chemotherapy?
32.	Yes	No	Rheumatic fever?	45.	Yes	No	HIV/AIDS?
33.	Yes	No	Stroke, hardening of arteries?	46.	Yes	No	Arthritis, rheumatism?
34.	Yes	No	High blood pressure?	47.	Yes	No	Eye disease?
35.	Yes	No	Prosthetic heart valve	48.	Yes	No	Skin disease?
36.	Yes	No	Pacemaker?	49.	Yes	No	Anemia?
37.	Yes	No	Asthma, TB, emphysema, other lung disease?	50.	Yes	No	Herpes?
36.	Yes	No	Hepatitis, other liver disease?	51.	Yes	No	Venereal disease?
37.	Yes	No	Stomach problems, ulcers?	52.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Thyroid disease?	53.	Yes	No	Hospitalization?
39.	Yes	No	Diabetes?	54.	Yes	No	Surgeries?
40.	Yes	No	Artificial joint?	55.	Yes	No	Blood transfusions?
41.	Yes	No	Pre-medication required by physician?	56.	Yes	No	Contact lenses?

IV. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:

57.	Yes	No	Local anesthetics ("Novocaine")	61.	Yes	No	Sulfa drugs?
58.	Yes	No	Penicillin?	62.	Yes	No	Reaction to metals?
59.	Yes	No	Aspirin, acetaminophen or ibuprofen?	63.	Yes	No	Latex or rubber dam?
60.	Yes	No	Codeine or other narcotics?	64.	Yes	No	Other _____

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines, natural remedies?	64.	Yes	No	Alcohol?

Please list: _____
_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications:

Patient's signature: _____ Date: _____
Doctor's signature: _____ Date: _____

My Smile

Jeannie Ju, DDS and Sung Ju, DMD

Patient Name: _____Date: _____

Please take a few minutes to answer the following questions so that we can help you have the smile that you have always wanted!

1) What do you like BEST about your smile?

2) What do you like LEAST about your smile?

3) Are you able to chew/speak well? ❒ Yes ❒ No
   If no, please explain why:
   _____

4) Do your gums bleed when you brush and/or floss? ❒ Yes ❒ No
5) Do you experience dry mouth? ❒ Yes ❒ No

6) Are your teeth…
   a. Chipped? ❒ Yes ❒ No
   b. Protruding? ❒ Yes ❒ No
   c. Crowded? ❒ Yes ❒ No
   d. Spaced apart? ❒ Yes ❒ No
   e. Worn? ❒ Yes ❒ No

7) Do you like the shape of your teeth? ❒ Yes ❒ No
   If no, please explain why: _____

8) Do you like the color of your teeth? ❒ Yes ❒ No
9) If no, please explain why: _____

10) Please tell us about any old dental work that you are not happy with:

11) Would you like to change the appearance of your teeth by…
   a. Reshaping them? ❒ Yes ❒ No
   b. Straightening them? ❒ Yes ❒ No
   c. Whitening them? ❒ Yes ❒ No
12) Why did you leave your last dentist?

13) If you could have ANY smile, my smile would look like…

PERMISSION TO USE X-RAYS, PHOTOGRAPHS AND VIDEOS

Patient Name: _____

I authorize Sung Ju, DMD, Jeannie Ju, DDS and/or their corporation to take x-rays, photographs and/or videos of me, including without limitation my face, teeth, smile and dental conditions. These materials may reveal my name and identity.

These x-rays, photographs and/or videos will become the property of Sung Ju, DDM and Jeannie Ju, DDS and/or his corporation. They may be published in dental journals, shown for educational purposes, showcased in the dental office, disseminated on the internet or social media, displayed in advertising, used on a web site and/or used for other commercial purposes. I authorize Sung Ju, DDS, Jeannie Ju, DMD and/or his corporation to reveal my name, identity and the fact that that I am his/her patient.

I waive any right to claim a confidential, proprietary or other interest in these materials or any financial or other benefits gained from their use.

_____ _____

Patient's Signature Date

_____

Witness

Financial Policy

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care. We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. Please read and sign this form in order to proceed with your scheduled appointment.

Payment
The patient portion due for services rendered is expected at time of scheduling unless *previous* arrangements have been made with the treatment coordinator and/or business administrator. We accept cash, checks and all major credit cards.

Insurance Assistance
Insurance claims are filed as a courtesy to you, our patient. Our goal is to maximize your insurance benefits and make any remaining balance easily affordable. Any portion, not expected to be covered by these benefits, is the responsibility of the patient and due at the time dental treatment is performed. This amount includes any deductibles and co-payments. Please understand that this is only an estimate – not a guarantee of payment, and is solely based on the information available to us from your insurance company.

Financial Assistance
Our fees are based on the quality of the materials we use and our experience in performing your needed treatment. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. To facilitate this goal, we are pleased to offer outside financing through Care Credit. Please ask our Office Manager for further details.

No Shows/Missed Appointments
We request notice to cancel or reschedule an appointment at least 48 hours in advance. If 48 hour notice is not given, a charge of $50 may be assessed to the patient's account.

Collections
When our office has made repeated attempts to collect a balance due, we may need to turn an account over to collections. The financially responsible party signing below shall pay all fees incurred while collecting on their family account.

Signature of Financially Responsible Person Date

Financially Responsible Person (Print)

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 16, 2014, 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:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- 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.

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

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.

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.

Our Privacy Official: Jeannie Ju, DDS
Telephone: 520.825.8112
Fax: 520.825.2242
Address: 15631 N. Oracle Rd. #187, Tucson, AZ 85739
E-mail: contact@creativesmilesdentistry.net

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have read this office's Notice of Privacy Practices.

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)

_____

_____

_____

COVID-19 Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have dental
(Print Name)
treatment completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ **(Initial)**

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ **(Initial)**

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ **(Initial)**

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ **(Initial)**
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ **(Initial)**

_____ _____

Signature **Date**