DR.JUN
DENTAL CARE

REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
If child, Parent's Name			Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security number:		Mobile number: ( )	
City:	State:	ZIP Code:	Email:		
Occupation:	Employer:		Employer phone no.: ( )		
How did you find out about our practice?					
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policyholder name:	Policyholder birth date: / /	Policyholder Social Security number:	Home/Cell phone no.: ( )
Address (if different):			
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:		Employer phone no.: ( )
Employer address:			
Is this patient covered by insurance? ❑ Yes ❑ No			
Insurance company:			

Group number:	Policy number:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Parents ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL HEALTH HISTORY			
Primary care physician:	Phone:	May we request health information if necessary for our treatment?	❑ Yes ❑ No
Are immunizations current? ❑ Yes ❑ No			

ALLERGIES	
	Reaction:
	Reaction:
	Reaction:

SURGERIES		
Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS (VITAMINS, INHALERS)			
Name the Drug	Strength	Frequency Taken	Indication

SOCIAL HISTORY					
Alcohol	Do you drink alcohol?			□ Yes	□ No
	How much do you drink per week?				
Tobacco	Do you use tobacco?			□ Yes	□ No
	□ Cigarettes – pks./day	□ Chew - #/day	□ Pipe - #/day	□ Cigars - #/day	
	□ # of years	□ Or year quit			
Drugs	Do you currently use recreational or street drugs?			□ Yes	□ No

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PAST MEDICAL HISTORY – please check if you have or ever had any of the following

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

☐ Alcoholism	☐ Deep vein thrombosis	☐ Organ Transplant
☐ Anemia	☐ Depression	☐ Osteoporosis
☐ Anticoagulation therapy	☐ Diabetes mellitus	☐ Pacemaker
☐ Anxiety	☐ Drug dependence	☐ Pancreatitis
☐ Arthritis	☐ Epilepsy	☐ Rashes/ Skin Problem
☐ Artificial heart valve	☐ Fibromyalgia	☐ Sexually Transmitted Disease
☐ Artificial joints (i.e. knee, shoulder)	☐ GERD (heartburn)	☐ Sickle Cell Anemia
☐ Asthma	☐ Heart disease	☐ Sleep Apnea
☐ Auto immune disease	☐ Hepatitis B	☐ Thyroid Disease
☐ Blood transfusion	☐ Hepatitis C	☐ Tuberculosis
☐ Cancer	☐ High cholesterol	☐ Ulcerative Colitis
☐ Chemotherapy	☐ High blood pressure	☐ Other:_____
☐ Cataracts	☐ HIV/AIDS positive	
☐ Cirrhosis	☐ Inflammatory bowel disease	_____
☐ Colon polyps	☐ Irritable bowel syndrome	
☐ Congestive heart failure	☐ Kidney disease	
☐ Coronary artery disease	☐ Liver Disease	For women only:
☐ Crohn's disease	☐ Mental disease	☐ Are you/possibly pregnant?
	☐ Myocardial Infarction (Heart Attack)	☐ Nursing

FAMILY HEALTH HISTORY

Please check id any member of your family (i.e. spouse, children, parents, siblings) has every had any of the followings:

☐ Allergies
☐ Auto immune disease
☐ Cancer
☐ Diabetes mellitus
☐ Heart disease
☐ Hepatitis B
☐ Hepatitis C
☐ High cholesterol
☐ High Blood Pressure
☐ Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Jun Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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14414 Old Mill Road, #101
Upper Marlboro, MD 20772
(301) 627 - 6646

Fee Policy

Payment is expected when services are rendered unless other arrangements are made in advance. The patient should provide a copy of insurance benefits if available so our staff can interpret the benefits. The patient must also provide the proper insurance forms. The patient may assign benefits to the dentist. If this is done, then the patient is responsible for 25% of the fee at the time of the service. If the patient does not wish to assign benefits he/she is then responsible for 100% of the fee. All fees for cosmetic treatment must be paid in full prior to initiating treatment. The office staff will submit claims to the patient's insurance company, however. Not all insurance companies will agree to pay the office directly. Therefore, you may be required to pay for services and then be reimbursed by your insurance company. No dental insurance plan attempts to cover all dental costs. It is the patient's responsibility to understand their insurance coverage. The staff will be happy to help the patient maximize benefits, however, the agreement of the insurance company to pay for a patients dental treatment is a contract between the patient and the insurance company which is responsible to the patient for payment of covered services and have no obligation to Sung Jun, DDS PC

Office cancellation policy: the patient must request cancellation or rescheduling at least 24 hours before the appointment. The cancellation or missed appointments without 24 hour notice will result in a charge of $50 to the account.

Financial arrangements must be made prior to the initiation of each phase of treatment. Any balance 30 days past due will incur a 1.5% late charge, which is assessed monthly. Balance over 90 days past due will be sent to a third party collection agency. If collection procedures become necessary the patient agrees to pay, in addition to the balance due and applicable late fees, all court costs and attorneys fees incurred as a result of the collection procedures.

I, the patient or responsible party, acknowledge receipt of the above fee policy.

Name of Patient (please print): _____

Name of Responsible Party (please print): _____

Signature of Responsible Party: _____

Date: _____

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TREATMENT CONSENT

I, _____(patient name), authorize and request Dr. Sung Jun and his dental staff to perform diagnostic and treatment procedures as are necessary for my proper dental care. I authorize her/him to do what she/he deems advisable if any unforeseen condition arises in the course of these procedures calling in their judgment, for procedures in addition to or different from originally contemplated.

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I understand that some after treatment effects and complications may occur.

I consent to the administration of local antibiotics, oral premedication, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug responses (e.g. allergic reactions), cardiac arrest, aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medication or drug.

I understand that inherent in any type of surgery are certain unavailable complications of surgery, the most common of these complication include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restoration. Less common complications can include infection fractures, sinus exposure, and swallowing or aspiration of teeth, restorations and dental materials, and small root fragments remaining in the jaw which might require surgery for removal.

I realize in spite of the possible complication and risks, my contemplated surgery or treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic to. I will follow all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I authorize release of any information concerning my healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits and release such information to another dentist, physician, or healthcare provider involved in my treatment.

Patient or Guardian Name (please print): _____
Patient or Guardian Signature: _____
Date: _____

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DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want Sung Jun, DDS (Provider) to disclose any information concerning my care, treatment or billing by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____

_____ _____

_____ _____

_____ I authorize Provider to discuss information related to my bill with the following named individual(s):

_____ _____

_____ _____

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____

_____

Patient or Guardian Name (please print): _____

Patient or Guardian Signature: _____

Date: _____

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PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that Dr. Jun Dental Care may send to you any of the following that you identify as communication that can be sent through the internet to an email address you designate.

Consent and Acknowledgement

I _____, in the presence of my dentist or the dental practice's privacy official or representative, agree that the practice may electronically communicate with me at the following email address.

Email Address (Please Print Clearly) _____

Patient's Date of Birth (for verification purposes) _____

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

_____ Information about my invoice or accounts payable. _____ (initials)

_____ Information about a specific dental visit. _____ (initials)
Specify:
_____ Information about any dental visit. _____ (initials)

_____ Breach Notifications _____ (initials)

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

_____ All electronic communications from our practice will not be encrypted and that there is some level of risk that third parties may be able to read unencrypted emails.

_____ I am responsible for providing the dental practice any updates to my email address.

_____ I am able to receive information electronically and store it securely away from any public computers.

_____ I can withdraw my consent to electronic communications by calling 301-627-6646

Patient's Signature _____ Date_____

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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.

Print Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but 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)

_____

_____

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NOTICE OF PRIVACY PRACTICE
(Please retain this copy)

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 January 3, 2017, 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.

DR.JUN
DENTAL CARE

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: Dr. Sung Jun

Telephone: 301-627-6646 Fax: 301-627-4996

Address: 14414 Old Mill Rd., #101, Upper Marlboro, MD 20772

E-mail: info@drjundentalcare.com