HOUSTON PERIODONTICS

Periodontics & Dental Implants
H. Chu Kim, DDS, MS, PA
Board Certified

Patient Information

Legal Name:_____ **Date** _____
First **Last** **MI**

Do you have another name you preferred to be addressed by? _____

Address:_____
Street **City** **State** **Zip**

Home:(_____)_____-_____ Work:(_____)_____-_____ Cell:(_____)_____-_____

E-Mail_____

Date of Birth: _____ **Sex: Male Female**

SSN#_____ **Marital Status:** Single Married Widowed Divorced Separated

Employer/School_____

Whom may we thank for referring you to our practice? _____

Do you have dental benefits? Y N

Dental History

Who is your family dentist? _____ Phone Number _____

When was your last visit to the dentist?_____

What was the nature of your last visit?_____

Have you had periodontal treatment before? **Y N**

If yes, when?_____

where?_____

type of treatment_____

How often do you have your teeth cleaned:_____ Most recent cleaning:_____

Dental Concerns

What is your biggest concern about your gums, mouth, or teeth?

How would you feel if you had to lose your teeth?

Check the following conditions if they apply to you:

- ❑ Swollen or bleeding gums
- ❑ Bad breath or mouth odors
- ❑ Bad tastes
- ❑ Painful gums or teeth
- ❑ Sensitivity to hot, cold, or sweets
- ❑ Clenching, or grinding of your teeth
- ❑ Loose teeth
- ❑ Increasing spaces between teeth

Primary Care Physician

Physician's Name _____ Phone Number_____

Last seen_____ Reason_____

Are you currently under the care of a physician? **Y N**

If yes, please explain_____

Medical History

(Please circle)

Are you allergic to any medications?..... **Y** **N**
If yes, please specify _____
Have you had any serious illness, operation, or hospitalization in the **past two years**?..... **Y** **N**

If yes, please specify _____
Has there been a change in your health in the **past two years**?..... **Y** **N**

If yes, please specify _____
Are you a bleeder or have excessive bleeding following dental treatment?..... **Y** **N**

Do you smoke or use tobacco products? ..... **Y** **N**
If yes, how much_____ how long_____

Do you drink alcoholic beverages? ..... **Y** **N**
If yes, how much_____ how often_____

Have you had any of the following?

(Please place an 'x' to indicate yes)

____High Blood Pressure
____Heart Murmurs
____Prolapsed Mitral Valve
____Rheumatic Fever
____Heart Problems
____Angina
____Heart Attack
____Heart Bypass Surgery
____Pacemaker
____Stroke
____Tuberculosis
____Emphysema

____Asthma
____Sinus Problems
____Dialysis
____Kidney Disease
____Treatment for Chemical Dependency
____Hepatitis/Liver Disease
____H.I.V. Positive
____AIDS/AIDS Related Complex
____Diabetes
____Thyroid Disorders

____Bleeding Problems
____Blood Disorders
____Osteoporosis
____Arthritis
____Joint Implants
____Nervous Disorders
____Epilepsy/Seizures
____Headaches
____Steroids (Past 2 years)
____Cancer

____Radiation/Chemotherapy
____Complications with Oral Surgery

Other _____

Women Only

Are you **currently?**
____Pregnant
____Nursing

List *ANY* drugs/medications that you are currently taking.

(Please include prescription/non-prescription drugs)

Drug	Dosage/How often?	How Long?

The health information provided is true and accurate to the best of my knowledge. I understand and agree that it is my responsibility to notify the doctor and or staff of any changes in my health and or medications.

X_____ _____

Patient's Signature **Date**

OFFICE USE ONLY

Baseline Blood Pressure_____ / _____

Medical Alert

Type of Brush Used Manuel Electric
Brush Firmness Soft Medium Hard
Brushes _____ x Daily Weekly
Flosses _____ x Daily Weekly Monthly

Medical History Reviewed_____ _____
Doctor's Signature **Date**

Patient Account Information

Patient's Name _____ **Date of Birth**_____

Responsible Party **(please make a selection)**

□ **Self** □ **Spouse** □ **Parent/Guardian** □ **Other** _____

Name _____ Date of Birth_____

SSN _____

Address_____

Street City State Zip

Dental Benefits Information

Policy Holder's Name_____ Relation to Patient _____

Policy Holder's Date of Birth _____ Policy Holder's **SSN** _____

Policy Holder's Address_____

Street City State Zip

Policy Holder's Employer_____

Employer's Corporate Address _____

Name of Dental Benefits _____

Dental Benefits Customer Service Phone Number _____

I authorize the release of any information necessary to process every claim pertaining to my or my dependant(s)'s treatment. I am aware Dr. H. Chu Kim does not accept assignment of dental benefits for non-contracted insurance companies. I am also aware Dr. Kim's office does not file claims for non-contracted insurance companies. I am responsible for all charges incurred for services rendered to me and/or my dependant(s). I understand payment is expected in full when services are rendered.

X_____ _____

Signature **Date**

Information Regarding Dental Benefits and our Office Policy

Dental benefits are playing a larger and larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental benefits with you. We consider our relationship with you to be of primary importance, and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your dental benefits provider and your employer. Our office is contracted with Aetna Dental PPO and Delta Dental PPO only. If you have any other dental benefits provider we will provide you all the necessary paperwork to maximize your dental benefits, but to reemphasize; we have no relationship or responsibility to your dental benefits provider.

Fact #1: Dental Benefits is not meant to be a "Pay-All", it is only meant to be an aid.

Fact #2: Many plans tell their insured that they will cover "up to 80%" or "up to 100%". In spite of what you were told, we have found many plans cover 40% to 50% of the average fee. Some plans pay more …some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance", the less you'll receive. It is your responsibility to advise us of your dental benefits coverage and restrictions.

Fact #3: It has been the experience of many dentists that some companies tell their customers that "fees are above usual and customary fees" rather than stating "our benefits are low". Remember you get back what you and your employer put into your dental benefits less the profits of the insurance company. In dealing with over 1,000 dental benefit plans, most plans do not cover our fees.

Fact #4: Each plan has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

Fact #5: Many routine dental services are **NOT** covered by dental benefit carriers. We make our recommendations based on your dental health needs and not on what your dental benefits may or may not cover.

We will provide you copies of all the paperwork necessary to file your claim. If you have any questions regarding your dental benefits, please contact your dental benefits carrier regarding the specifics and details of the plan they are operating on your behalf. Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees.

Consent for Use and Disclosure of Health Information

Health Insurance Portability and Accountability Act

Please read the following carefully.

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 is available upon request. 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:

Lisa Lee 4543 Post Oak Place Suite 108 Houston, Texas 77027 713.629.5170 Office 713.629.5172 Fax

Consent

I, _____**(please print)**, 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 for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: X_____ **Date: X**_____

If a personal representative on behalf of the patient is signing this consent, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

•• ••

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 or continue treating you if you revoke this Consent.**

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or continue to treat me after I have revoked my consent.**

Signature: _____ Date: _____

If a personal representative on behalf of the patient is signing this revocation of consent, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____