

Premier Dental Care
220 Horizon Dr., Suite F
Henderson, NV 89015

Alex Y. Song, D.D.S.

CHART # _____

Personal Information

Patient Name Last _____ First _____ Initial _____ Birthdate _____

Soc. Sec. # _____ Male _____ Female _____

Marital Status: Married _____ Single _____ Child _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Telephone # (____) _____ Cell Phone #(____) _____

Preferred Contact Number (circle one): Home / Cell / Work

Employer _____ Position _____

Employer Address _____ City _____ Zip _____

Employer Telephone # (____) _____ Fax # (____) _____

Parent/Spouse Name Last _____ First _____ Initial _____

Medical Physician of Above Patient _____

Telephone # (____) _____ Fax #(____) _____

Previous Dentist _____ Telephone # (____) _____

Name & Address

**** Emergency Contact ****

Name _____ Relationship _____ Phone # (____) _____

Dental History and Information

Are your teeth sensitive to heat or cold, pressure, or sweets? Yes NO Specify :
 Do your gums bleed when you brush? Yes NO
 Do you clench or grind your teeth? Yes NO
 Are you having pain or discomfort at this time? Yes NO Date of last exam _____

Medical History and Information

Are you under a physician's care now? Yes NO Reason _____
 Have you been hospitalized in the past two years? Yes NO Reason _____
 Are you taking any drugs or medications? Yes NO Reason _____
 Do you have artificial joints/pins ? Yes NO Where? _____

If female please answer the following:

Y N
 Are you taking Birth Control Pills?
 Are you pregnant? # of weeks?
 Are you nursing?

Please answer the following:

Y N
 Do you smoke or use tobacco?
FOR OFFICE USE ONLY
 BP _____ Heart
 Rate _____

Please CIRCLE Y (yes) or N (no) to all of the following:

Conditions	Conditions	Conditions
Y N Abnormal Bleeding	Y N Glaucoma	Y N Sinus Problems
Y N Alcohol Abuse	Y N Hay Fever	Y N Stroke
Y N Allergies	Y N Heart Attack	Y N Thyroid Problems
Y N Anemia	Y N Heart Surgery	Y N Tuberculosis
Y N Angina Pectoris	Y N Hemophilia	Y N Ulcers
Y N Arthritis	Y N Hepatitis A	Y N Venereal Disease
Y N Artificial Bones	Y N Hepatitis B	Y N Yellow Jaundice
Y N Artificial Heart Valve	Y N Hepatitis C	Y N Heart Murmur
Y N Asthma	Y N High Blood Pressure	Allergies
Y N Blood Transfusion	Y N HIV + AIDS	Y N Aspirin
Y N Cancer -Chemotherapy	Y N Kidney Problems	Y N Codeine
Y N Colitis	Y N Liver Disease	Y N Dental Anesthetics
Y N Congenital Heart Defect	Y N Low Blood Disease	Y N Erythromycin
Y N Cosmetic Surgery	Y N Mitral Valve Prolapse	Y N Jewelry
Y N Diabetes	Y N Pace Maker	Y N Latex
Y N Difficulty Breathing	Y N Pneumocystitis	Y N Metals
Y N Drug abuse	Y N Psychiatric Problems	Y N Penicillin
Y N Emphysema	Y N Radiation Therapy	Y N Tetracycline
Y N Epilepsy	Y N Rheumatic Fever	Other: _____
Y N Fainting Spells	Y N Seizures	_____
Y N Fever Blisters	Y N Shingles	_____
Y N Frequent Headaches	Y N Sickle Cell Disease	

Do you have or have you had any disease, condition or problem not listed above? Yes or No
 Explain _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I will inform the dentist and staff before the next appointment.

X _____ Date _____
 Patient or responsible party signature

FOR OFFICE USE: Reviewed by _____ Date _____

MEDICAL UPDATES

I have read my medical history dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Primary Insurance Information

Name of Insured Last _____ First _____ Initial _____

Soc. Sec. # _____ D.O.B _____ Relationship to patient _____

Address (if different from patient's) _____ Phone () _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Employers Address _____ Work Phone#() _____

Insurance Company _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insured Last _____ First _____ Initial _____

Soc. Sec. # _____ D.O.B _____ Relationship to patient _____

Address (if different from patient's) _____ Phone () _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Employers Address _____ Work Phone#() _____

Insurance Company _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Assignment of benefits: I hereby authorize and request my insurance company to pay directly to Premier Dental Care the amount due on my claim for services rendered to my dependant or me. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability were such that it is not covered by the policy, I will be responsible to Premier Dental Care for payment of the entire bill.

Signed: _____ Date: _____

Welcome to Premier Dental

CHART # _____

How did you hear about our office?

*** Please mark all that apply***

___ Friend or patient referral: Name of referring person _____

___ Specialist or other Dentist: Dentist name _____

___ Mailer /Advertisement ___ Sprint Yellow Pages

___ Physical Location ___ Yellow Book Yellow Pages

___ Insurance company referral ___ Discount Plan

___ Postcards ___ Internet

Are you happy with the appearance of your teeth? ___ Yes ___ No

Please check the boxes of all that apply:

- Do you have a toothache?
- Do you grind your teeth?
- Do your gums bleed?
- Do your jaw joints pop or click?
- Do you have pain in jaw joints?
- Do you have ringing or fullness in your ears?
- Headaches, if yes how often _____
- Loose teeth
- Broken or chipped teeth or fillings
- Bad breath
- Teeth sensitive to hot
- Teeth sensitive to cold
- Teeth sensitive to sweets
- Teeth sensitive to biting
- Teeth that trap food between them
- Have you ever been treated by an Orthodontist
- Have you ever been treated by a Periodontist

Why did you leave your last dentist? _____

Please list your sports activities and hobbies _____

Patient or parent's signature _____ Date _____

Premier Dental Care
220 Horizon Drive, Suite #F
Henderson, Nevada 89015
(702) 563-6956

Alex Y. Song, D.D.S.

TO OUR VALUED PATIENT:

CHART # _____

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask.

Payment for services is due at the time services are rendered. We accept Cash, Checks, MasterCard, Visa, Discover and American Express. We will submit an insurance claim on your behalf if you show proof of coverage. However, to establish your account, you may need to pay the deductible if required by your insurance company. If your insurance company/coverage changes, please notify us immediately.

Please understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a third party to that contract. Our relationship is with you, the patient. If we are a preferred provider, your co-pays/deductibles are due at the time of treatment. You are responsible for knowing your insurance benefits. Is Preauthorization required for any treatment exceeding \$500? Is your insurance a PPO or is it an open plan? If we can be of assistance, please let us know.

2. Although we routinely try to secure payment from your insurance company by acting as the go-between, all charges are your responsibility whether the insurance company pays or not. You will continue to be responsible for all balances on your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Fees for these services, along with the unpaid deductibles and co-payments are due at the time of treatment.

3. Please keep in mind that we will bill your insurance company as a courtesy for any charges that are rendered, but what we estimate for them to pay is just an estimate and whatever is not paid by them is your responsibility to pick up. If your insurance company does not pay in full within 30 days, we ask you contact your insurance company to check status and keep in contact with them until they send payment. We expect prompt payment from you within 10 days of statement received for any balance due after insurance pays.

4. Any balance due on account over 120 days without payment arrangements will be turned over to the collection agency representing our office. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees, or court costs.

5. Returned checks are subject to a \$25 returned check fee.

6. We reserve the right to charge \$25 per hour for appointments cancelled or broken without 24 hours advance notice. We have an answering machine available 24 hours a day and as long as we receive your message first thing in the morning to cancel or reschedule your appointment there will not be a charge.

7. No minor children (under the age of 18 yrs old) will be treated without a parent present at all times.

8. Payment and co-pays for major treatment (crowns, bridges, partials, and dentures) are due on the day services are rendered before we begin treatment.

9. The VIP referral credit of \$25 will only be applicable and applied to your account if the person you are referring brings in a referral card at the time of their first visit with your name on it.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status or any of the above information.

Signature of Patient

Date

HIPPA Notice of Privacy Practices

Name: _____ Chart#: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your (PHI) information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by a physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your name, photograph, and email address in order to obtain a LumiSmile picture. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Laws Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of health and human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Chart#: _____

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on / or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our (702) 563-6956.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Please provide the following information if you would like to authorize our office to release your information: (optional)

I, _____, authorize the release of treatment and financial records pertaining to _____ (patient name) to the following people:

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect you privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations. In order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal health information, but this must be in writing. Under this law. We have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ Date: _____

COMPLIANCE ASSURENCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, Managers and Doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the " Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure the practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions:

1 Do you like the appearance of your teeth and your smile? Yes No
If not, explain _____



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)? Yes No
If not, explain _____



SPACES

3 Do you have spaces that you don't like? Yes No
If yes, explain _____

4 Do you like the color of your teeth? Yes No
If not, explain _____



CALCIFICATION STAINS

5 Do you like the shape of your teeth? Yes No
If not, explain _____

6 Are your teeth...
Chipped? Yes No Protruding Yes No Hidden Yes No
If yes, explain _____



FANGED TEETH

7 Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain _____



PORCELAIN CROWNS

9 What would you like to change the most in the appearance of your teeth?

10 How would you like your teeth to look?



BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.



LUMINEERS
BY CERINATE®
lumineers.com

Premier Dental Care

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Henderson, NV 89015
(702) 563-6956

PERMISSION TO UTILIZE PATIENT'S RECORDS

I hereby grant Dr. Alex Y. Song and Associates permission to use the diagnostic and treatment photographs, models, and records of:

(Patient's name)

for the purpose of display for office, website, scientific articles, seminars, presentations, etc.

Patient Signature (Parent or guardian if patient under 18 yrs old)

Date