YOUNGS FAMILY DENTISTRY
Young Woo Lee, DDS

REGISTRATION FORM

PLEASE PRINT

PATIENT'S NAME _____ SEX: M F

NAME PATIENT WOULD LIKE TO BE CALLED _____

SOCIAL SECURITY NUMBER _____ BIRTHDATE _____ AGE _____

MOTHER'S NAME _____

HOME NUMBER _____ WORK NUMBER _____

SOC SEC # _____ BIRTHDATE _____

FATHER'S NAME _____

HOME NUMBER _____ WORK NUMBER _____

SOC SEC # _____ BIRTHDATE _____

PERSON REPONSIBLE FOR THIS ACCOUNT _____

ADDRESS _____

If different from above: HOME # _____ SOC SEC # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____

INSURANCE GROUP # _____ PHONE # _____

SUBSCRIBER'S NAME _____

SECONDARY INSURANCE CO. _____

INSURANCE GROUP # _____ PHONE # _____

SUBSCRIBER'S NAME _____

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage.
I authorize release of any information relating to any claims for services rendered to me to my insurance company(s).
I authorize payment directly to Dr. Young Woo Lee or YOUNG'S FAMILY DENTISTRY of the insurance benefits otherwise payable to me.
I understand I am financially responsible for any charges not payable by my insurance company(s).

_____ _____
SIGNATURE (INSURED NAME) DATE

_____ _____
SIGNATURE (INSURED NAME) DATE

MEDICAL HISTORY

Patient Name: _____ Date of birth: _____

Name of Medical Doctor: Dr._____ Date of last physical exam: _____

Phone # _____

List all the medication you are **currently taking**:

_____
_____
_____
_____
_____

List all the medication you are **allergic** to:

_____
_____
_____
_____
_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR NOW HAVE

AIDS:_____
Anemia:_____
Arthritis:_____
Artificial heart valve:_____
Asthma:_____
Cancer or tumor:_____
Chest pain:_____
Diabetes:_____
Epilepsy/Seizure:_____
Glaucoma:_____

Heart murmur:_____
Heart surgery:_____
Heart trouble:_____
Hepatitis:_____
High blood pressure:_____
HIV positive:_____
Joint replacement:_____
Kidney disease:_____
Liver disease:_____
Neurological disease:_____

Psychiatric treatment:_____
Pacemaker: _____
Rheumatic fever:_____
Sinus trouble:_____
Stroke:_____
Tuberculosis:_____
Ulcers:_____
Venereal disease:_____
Osteoporosis:_____
Hypo/Hyper Thyroid :_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. YES NO Are you currently seeing medical doctor for any treatment?
   If yes, please explain:_____
2. YES NO Have you been hospitalized or had any surgery in the past year?
   If yes, please explain:_____
5. YES NO Pregnant or possibly pregnant? If yes, when due? _____
6. YES NO Taking birth control pills?
7. YES NO Any other medical history that we should know about?
   If yes, please explain:_____
8. YES NO Do you use tobacco? If yes, circle CHEWING or SMOKE How often? _____

Patient Signature: _____ Date: _____

Pre-med allergies hepatitis heart BP medication anesthetic N2O other

DENTAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is the purpose of this dental visit? _____
2. YES NO Are you having any pain or discomfort now?
   If yes, please list your dental concerns: _____
   _____
   _____
3. YES NO Have you had a bad dental experience? If yes, When: _____
4. Last dental cleaning or exam date: _____
5. Last dental treatment date: _____ Reason: _____
6. Who was your former dentist? Dr._____ City _____
   Phone #_____

PLEASE CHECK ANY THAT APPLY

- O Apprehensive about dental treatment
- O Clench jaw or grind teeth frequently
- O Pain in the face, cheek, jaws, joints, throat, or temples
- O Had a trauma (blow) to the jaw or teeth
- O Gag easily
- O Gum bleed easily
- O Floss daily
- O Dissatisfied with the appearance of your teeth
- O Wants whiter teeth
- O Interested in BOTOX
- O Need Implant, missing tooth
- O Sleeping Disorder / Sleep Apnea
- O Sensitive teeth to cold and/or hot
- O Like gentle cleaning

Comments:

_____

_____

_____

_____

_____

_____

_____

YOUNGS FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Name: _____ DOB: _____

Address: _____

Phone: _____ S.S. #: _____

TO THE PATIENT – Please read the following statements 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 disclosure 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 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 revisions of our Notice, at any time by contacting:
Contact Person: Dr. Young W. Lee
Address: 30821 14th Ave S. Federal Way, WA 98003
Phone: 253-839-0660

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.

SIGNATURE
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: _____ **Date:** _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT - ***DO NOT*** sign if signed above

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

Signature: _____ Date_____

YOUNGS FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICE

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.

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. This Notice takes effect 04/14/2003, 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 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 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.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.

Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

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 authorization 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 if you do not object or in an emergency.

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (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. If you request copies, we will charge you a reasonable cost-based fee for expenses such as copies and staff time.

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 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 restriction 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 to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments 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 by amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

We support your right to the privacy of your health information. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your rights have been violated. We will not retaliate against you for filing a complaint with us or with the U.S. Department of Health and Human Services.

For more information about our Privacy Practices, please contact:

Dr. Young W. Lee
30821 14th Ave S.
Federal Way, WA 98003

Telephone: 253-839-0660
Fax: 253-839-6336
e-mail: yfd2001@gmail.com