PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ycung C. Park D.D.S., PC

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Young C. Park, DDS, PC
623 Abney Rd
Roanoke, VA 24012

Appointment Policy

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health. For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves. If we have to raise our fees to offset the cost of missed appointments, our responsible patients pay the price for the irresponsible ones and we don't think that's fair. We want to keep our fees as low as possible for our patients by working efficiently and trusting them to keep their scheduled appointments.

In an effort to more effectively keep our schedule full and your fees down, we are making some changes to our "Appointment Policy".

- We will charge a fee of $65 for failed appointments or cancellations with less than 24 hours notice. While we understand you might feel you are being "charged for nothing", please understand that every lost appointment costs us much more than $65. Failed appointments mean NO income but we still pay staff salaries, utilities, etc for that time.
- Charges for late cancellations or failed appointments are due immediately.
- Patients who fail to come for confirmed appointments or cancel without 24 hours notice on 3 appointments in a 12 month period may be asked to find another dental office for their treatment.

It is our goal to keep our schedule full and your costs down. We thank you for understanding that we have your interests as well as ours at heart. If something comes up requiring you to cancel an appointment, we respectfully ask for advance notice so we have time to fill that appointment with other patients' treatment.

We would like you to understand and agree with this policy as we begin treatments. Please ask for any clarification if you have any questions or concerns regarding our appointment policy.

I UNDERSTAND THE APPOINTMENT POLICIES AND AGREE TO ABIDE BY THEM. ANY QUESTIONS I HAVE ABOUT THESE POLICIES HAVE BEEN EXPLAINED TO ME.

Print Name: _____ Date: _____

Signature: _____

Young C. Park, D.D.S. PC
623 Abney Road
Roanoke, VA 24012
(540)563-9398

OFFICE PAYMENT POLICIES

All fees will be due and payable on the day of treatment. We accept cash, check, bankcards (Visa, Master Card, Discover), Care Credit (an in office payment plan), or verified coverage from your dental insurance provider for covered procedures.
If an appointment is failed or cancelled without a 24 hour notice, there will be an office fee charged to the patient in the amount of $65.00.

If you are a regular patient in the practice and have established a good credit record with this office, we will be glad to offer an alternate payment schedule for proposed treatments. If payments are not received as promised, a service charge will be added to the account for the current monthly billing period (or a minimum charge of $5.00.)

IF YOU HAVE DENTAL INSURANCE COVERAGE: Do you know your Plan?

1.) Some dental insurance plans will cover examinations and preventive procedures at 100%. Patients with such a plan would not be required to make co-payments when these procedures are contemplated.

2.) Some dental insurance plans will have a $25 - $50.00 deductible even for examinations and preventive procedures. This deductible would need to be paid at the examination visit.

3.) If the examination results in the need for restorative or periodontal procedures, a preauthorization for the needed work over the amount of $300.00 would be sent to your insurance carrier. This preauthorization of benefits will tell us at what level they will be paying on the proposed procedures. **The portion that is not covered by your insurance would need to be paid at the date of service.** If we don't pre-auth procedures we will give you the best estimate due for your next scheduled appointment.

IF YOU HAVE DENTAL INSURANCE AND WISH TO FILE THE CLAIMS YOURSELF, OR FAIL TO SHOW VERIFICATION OF INSURANCE, ALL FEES WOULD BE DUE AND PAYABLE AT THE TIME OF TREATMENT.

01/2013

ACKNOWLEDGEMENT
OF
OFFICE POLICIES AND PRIVACY PRACTICES

My signature confirms that I have received and have been informed of the Office policies and my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) at Dr. Young C. Park's Office. I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Office Policy and Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Office Policy and Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Office Policy and Notice of Privacy Practices* and that I may contact this office at the address below to obtain a current copy of the *Office Policy and Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office use Only:
We were unable to obtain the patient's written acknowledgement of our Office Policy and Notice of Privacy Practices due to the following reason:

The patient refused to sign

Communication barriers

Emergency situation

01/2013

Dr. Young Park,D.D.S.PC 623 Abney Road, NW. Roanoke, VA 24012 (540)563-9398

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

[] **Treatmen**t 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 service, confirming, 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.

Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/ or leave messages at home and /or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

[] The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

[] The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

[] The right to access, inspect and copy your protected health information.

[] The right to request and amendment to your protected health information.

[] The right to receive an accounting or disclosures of protected health information outside of treatment, payment and health care operations.

[] The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of your legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practice will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a forma, 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 privacy rights have been violated. We will not retaliate against you for filing a complaint.

For information about our Privacy Practices, please contact:
Young C. Park, D.D.S.
623 Abney Road, N.W.
Roanoke, VA 24012 (540)563-9398
01/2013

For information about HIPPA or file a complaint:
U.S.Dept. of Health & Human Services
Office of Civil Rights, 200 Independence Ave
Washington, DC 20201 (877)696-6775 toll free

Smile Evaluation

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

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

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

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

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 _____
_____

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 _____
_____

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

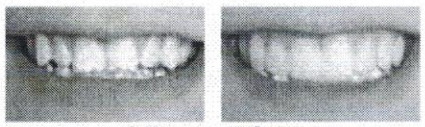
8 Are there old fillings or dental work you don't like looking at? □ **Yes** □ **No**
If yes, explain _____
_____

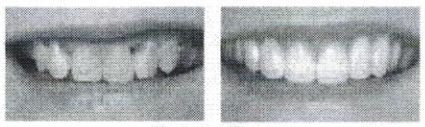
9 What would you like to change the most in the appearance of your teeth?
_____
_____

10 How would you like your teeth to look?
_____
_____


Stained and Chipped


Spaces


Calcification Stains


Fanged Teeth


Stained and Crooked Teeth


Porcelain Crowns


Beautiful Smile

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

LUMINEERS®

snap on smile®

duo PCH™
Porcelain Composite Hybrid

Young C. Park, DDS, PC
623 Abney Rd
Roanoke, VA 24012

Denture Wearer Survey

Name: _____ Date: _____

1. What kind of denture do you wear?

   Upper: Partial or Full Lower: Partial or Full

2. How long have you worn dentures?

   Upper:_____ Lower:_____ Your Age: _____ Sex: M F

3. How often do you visit the dentist? _____ When was your last visit? _____
4. How many dentures have you had made since the loss of your natural teeth?
5. Age of your current denture?_____How many relines have you had?_____

   Last reline? _____
6. Do you use denture adhesive? Yes or No How often do you use them?_____
7. Please explain to me your experience(s) with denture adhesives

   (Good/Bad):_____

   _____
8. Are you able to eat any food you want with your dentures? Yes or No If no, what foods are you unable to eat? _____
9. What do you miss most about your natural teeth?

   _____
10. Explain how you life has changed since you started wearing dentures?

    _____

    _____

    _____