Dr. Man Sunwoo, DMD

Patient Information Form

Name ____ Date ____________
First Middle Last

Address ____________________ City ____________ State ________ Zip ________

Home phone # ____________ Work phone # ____________ Cell # ____________ Birthdate ____________

Email ____ Soc. Security # ____________

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school ____________________ City ____________ State ________

Patient or parent's employer ____

Business address ____________________ City ____________ State ________ Zip ________

Spouse or parent's name ____________________ Employer ____________ Work phone ____________

Whom may we thank for referring you ____

Person to contact in case of an emergency ____________________ Phone ____________

Responsible Party (if different than patient)

Name of person responsible for this account ____________________ Relationship to patient ____________

Address ____ Home phone ____________

Driver's license # ____________ Birth Date ____________ Soc. Security # ____________

Employer ____ Work phone ____________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured ____ Relationship to patient ____________

Birthdate ____________ Soc. Security # ____________ Date employed ____________

Name of employer ____________ Union or local # ____________ Work phone ____________

Insurance Co. ____________________ Tel. # ____________ Grp. # ________ Policy/I.D.# ________

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ____________ Soc. Security # ____________ Birthdate ____________

Name of employer ____________ Union or local # ____________ Work phone ____________

Insurance Co. ____________________ Tel. # ____________ Grp. # ________ Policy/I.D. # ________

Ins. Co. address ____________________ City ____________ State ________ Zip ________

X____
Signature of patient (or parent, if minor)

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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: ____

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ____

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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.

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SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ________________

Dr. Man Sunwoo, DMD

Office Policies

It is our goal to provide you and your family with the highest quality dental care while maintaining a friendly and relaxing environment. In order to keep such high standards, we ask that you observe the following guidelines.

Payment & Office Policies

Cost
The cost of treatment depends on the severity of the patient's problem. You will be able to discuss fees and payment options before treatment begins. We have payment plans to suit different budgets. We also accept assignment from most insurance plans, and as a courtesy to you will file the necessary papers to the insurance company.

Fees
In an effort to keep your fees down while maintaining the highest level of professional care, we have established this financial policy:

- Full payment (minus any estimated insurance) is due at the time of treatment
- For your financial convenience, we offer many different extended payment plans, some even interest free, through CareCredit. Please inquire with our staff or visit their website at www.CareCredit.com
- We will also accept payment via VISA, Mastercard, American Express, Discover, personal check or cash.

Insurance
If you have insurance, we will help you to determine the coverage you have available. We will help in every way we can in filing your claim and handling insurance questions from our office on your behalf. Please be aware that any portion left unpaid by your insurance company after 60 days will be your responsibility. **If your insurance company denies a claim, that portion will be expected upon denial. We will help you to appeal the claim, however, the balance is ultimately your responsibility.**

Cancellation Policy

Each appointment scheduled is a time that is reserved especially for you and your dental care. We will strive to see you on time at each appointment and ask that in return you are on time to your appointments. If you need to reschedule your reserved time with either Dr. Sunwoo or our hygienist, we require at least a 48 hour (2 day) advance notice. If the request to reschedule or cancel the appointment is not made within this time frame, a fee in the amount of $75 per hour of cancelled appointment time will be assessed.

I acknowledge that I have received and reviewed the office policies.

X____
Patient or legal guardian signature

Dr. Man Sunwoo, DMD, PLLC

Privacy Policy/HIPAA Compliance

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.
We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care.
We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment: We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations: We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.
We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.
We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).
We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights
In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.

I acknowledge that I have received and read these privacy policies:

X____ Date:_________
Signature of Patient or Legal Guardian

STANDARD OF CARE

This is a notice to inform you that some insurance companies have recently altered their methods of processing claims and have downgraded many procedures to alternate, less desired, treatment options or stopped payment for certain procedures although it is a covered benefit.

We, at Bellevue Dental Excellence, will continue to always put your general and oral health as a top priority. Your oral condition will be carefully examined and all clinical findings will be thoroughly explained to you utilizing both x-rays and digital photographs. The treatment plan derived will be one which we believe to be the best treatment option for your condition.

As a courtesy to you, we will submit the performed treatment claims to your insurance company.

As explained above, the treatment standards of insurance companies are not always what we at Bellevue Dental Excellence believe to be ideal nor optimal, therefore, if a submitted claim is denied, the cost of the rendered treatment will be your responsibility and will be due immediately following the claim denial.

We will assist you in every effort if you so wish to appeal your claim with your insurance company.

I, ____ understand and accept the cost responsibility.

Signature:____ Date:________________________

Authorization for Use of Dental Photos

I, ______________________________, hereby release the use of any photos taken by Bellevue Dental Excellence for educational and diagnostic purposes. I understand that my identity will be held confidential.

O I release all photos, including those in which my face is visible.

O I release photos depicting TEETH ONLY.

________________________ ________________________

Patient Signature Printed Name

DECLINE the Use of my Dental Photos

I, ______________________________, DO NOT release the use of any photos taken by Bellevue Dental Excellence for any use.

________________________ ________________________

Patient Signature Printed Name

Man Sunwoo, DMD.

14700 NE 8th St. Suite 210. Bellevue, WA 98007. (425)378.1600. office@bellevuedentalexcellence.com