Patient Registration and Medical History

(please print)

Date _____ Preferred Name (Nickname) _____

Patient _____ Social Security # _____

Last Name First Name Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Birthdate: _____ Single: __ Married: __ Widowed: __ Separated: __ Divorced: __

Home phone: _____ Cell phone: _____ Email: _____

Preferred choice of contact: Home phone: __ Cell phone: __ Email: __ Text: __ (please choose one)

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Phone: _____

Spouse Employed by: _____ Occupation: _____

Insurance Information *(section must be filled out completely to process)*

Insured's Name: _____ Relationship to Patient: _____

Insured's Social Security # _____ *(Insurance cannot be processed without this)*

Insured's Birthdate: _____

Name of Insurance Company: _____ Do you have secondary insurance? _____

In case of emergency call: _____ Phone: _____

Referred by: _____ Phone: _____

If referred by a doctors office, do they have updated xrays (within the past 3 years): _____

Medical History

Are you under the care of a physician at this time? Yes / No If so, for what? _____

Physicians Name: _____ Date of last physical: _____

Do you need medical clearance for procedures? Yes / No Are you pregnant or nursing? (women only) Yes/ No

Do you have any allergies or adverse reactions to any medications? Yes / No If so, then what? _____

Have you ever responded adversely to any medical or dental treatment? Yes / No If so? _____

Are you taking any medications at this time? Yes / No If so? _____

Are you taking any blood thinners? Yes / No Are you pre-medicating? Yes / No If so? _____

Anything else we should know about your medical history? _____

>Please provide a list of medications for our records. Thank You.

Have you ever had any of the following? *(check any that apply)*

Heart Problems __	Epilepsy __	Special Diet __
High Blood Pressure __	Headaches __	Swollen Neck Glands __
Low Blood Pressure __	Hepatitis, Jaundice or Liver Disease __	Rheumatic Fever __
Circulatory Problems __	Cancer __	Sinus Problems __
Nervous Problems __	Psychiatric Care __	AIDS or other __
Radiation Treatment __	Chronic Diarrhea __	Immunosuppressive Disorders __
Artificial Heart Valves or joints __	Allergies to Anesthetics __	Stroke __
Recent Weight Loss __	Allergies to Medications or drugs __	Ulcer __
Back Problems __	General Allergies __	Venereal Disease __
Diabetes __	Blood Disease __	Chemical Dependency __
Respiratory Disease __	Arthritis __	Hemophilia __
Heart Murmur __	Mitral Valve Prolapse __	

The above information is accurate and complete to the best of my knowledge and is only for use in the treatment, billing and processing of insurance for benefits which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

JULIANA YUN DDS, PC
Periodontics and Dental Implants
Diplomate, The American Board of Periodontology

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Juliana Yun. DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment. payment for services. or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Juliana Yun. DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change. I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices. I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
MESSAGE ON WORK TELEPHONE:	☐ YES	☐ NO
MESSAGE ON HOME/CELL TELEPHONE:	☐ YES	☐ NO
NON SECURE:_____	☐ YES	☐ NO
OTHER (please specify):_____	☐ YES	☐ NO

_____ _____

Name of Patient or Personal Representative | **Signature of Patient** or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

OFFICIAL USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided Prior to Treatment?	☐ YES ☐ NO
Date Provided:	
Reason for Denial:	☐ Needed more time to review statement of privacy practices. ☐ Wanted to consult with another person. before signing. ☐ Unable to sign. ☐ Reason not given. ☐ Other (Explain): _____

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least **24 HOURS** in advance. Our doctors and hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within **24 HOURS.** For weekday appointments we require **24 HOURS** notice and Saturday appointments require **48 HOURS** notice.

As of August 1st 2015, there will be a fee of **$50.00** assessed if we do not receive a call to cancel a regular appointment and a fee of **$150.00** for surgical appointments.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Juliana Yun DDS, PC

Signature_____

Date_____

STATEMENT OF PRIVACY PRACTICE

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never by improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. while most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by the law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, text message and post cards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information uses and other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You cal also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concernting your privacy rights and the protection of your personal health information.

Juliana Yun DDS PC
116 N. Franklin Turnpike
Ramsey, NJ 07446
201-825-7677

x _____ Date _____