JOHN M. KIM, DMD
ORAL & MAXILLOFACIAL SURGERY

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

NAME:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE:

WORK/CELL PHONE:

SOCIAL SECURITY #:

AGE: BIRTHDATE:

EMAIL:

EMPLOYER/SCHOOL:

EMPLOYER/SCHOOL ADDRESS:

CITY: STATE: ZIP:

MARITAL STATUS: S☐ M☐ W☐ D☐

SPOUSE/PARENT NAME:

REFERRED BY:

GENERAL DENTIST:

EMERGENCY CONTACT:

EMERGENCY PHONE:

RESPONSIBLE PARTY INFORMATION (PRIMARY INSURED INFORMATION)

NAME:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE:

WORK/CELL PHONE:

BIRTHDATE: RELATIONSHIP:

SOCIAL SECURITY #:

EMPLOYER:

EMPLOYER ADDRESS:

CITY: STATE: ZIP:

IF SECONDARY INSURANCE

INSURED NAME:

EMPLOYER:

BIRTHDATE: RELATIONSHIP:

SOCIAL SECURITY #:

INSURANCE INFORMATION:

IF YOU HAVE AN INSURANCE CARD, PLEASE GIVE IT TO THE RECEPTIONIST TO COPY; IF YOU WISH FOR YOUR INSURANCE TO BE BILLED PLEASE COMPLETE ALL INFORMATION REGARDING THE INSURED BELOW.

MEDICAL INSURANCE CO:

ADDRESS:

CITY: STATE: ZIP:

PHONE:

POLICY #:

GROUP #:

NAME OF SUBSCRIBER:

SOCIAL SECURITY #:

BIRTHDATE:

DENTAL INSURANCE CO:

ADDRESS:

CITY: STATE: ZIP:

PHONE:

POLICY #:

GROUP#:

NAME OF SUBSCRIBER:

SOCIAL SECURITY #:

BIRTHDATE:

***TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED.**

PARENT OR RESPONSIBLE PARTY SIGNATURE

DATE

JOHN M. KIM, DMD
ORAL & MAXILLOFACIAL SURGERY

MEDICAL HISTORY

Name: **Birthdate:**

1. Are you now under a physicians care or have you been during the past 5 years? Y☐ N☐
   A. Name and phone numbers for all physicians you are currently under the care of:_______________

   ____

   ____

   B. List hospitalization(s) dates:_______________

   C. List surgeries:_______________

   ____

2. Has there been any change in your general health in the past year? Y☐ N☐
3. Date of your last physical exam:_______________
4. Are you now under a physician's care for a particular problem? Y☐ N☐
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: Y☐ N☐

   ____

6. Height__________ Weight__________ Blood Pressure__________ (we will check if necessary)
7. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   A. Local Anesthesia (Novocain, etc.)? Y☐ N☐
   B. Sedative, Barbiturates? Y☐ N☐
   C. Aspirin / Ibuprofen / Aleve? Y☐ N☐
   D. Latex or Rubber Products? Y☐ N☐
   E. Codeine or other pain killers? Y☐ N☐
   F. Any Antibiotics? Y☐ N☐ Please List:_______________
   G. Other allergies or reactions not listed above? Y☐ N☐ Please List:_______________
   H. Food Allergies? Y☐ N☐ Please List:_______________
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Rheumatic Fever or Rheumatic Heart Disease? Y☐ N☐
   B. Congenital Heart Disease? Y☐ N☐
   C. Cardiovascular Disease Y☐ N☐
      ☐Heart Attack ☐Heart Trouble ☐Heart Murmur ☐Coronary Artery Disease ☐Angina ☐High Blood Pressure
      ☐Stroke ☐Palpitations ☐Heart Surgery ☐Pacemaker
   D. Lung Disease Y☐ N☐
      ☐Difficulty Breathing ☐Asthma ☐Emphysema ☐Chronic Cough ☐Bronchitis ☐Pneumonia ☐Tuberculosis
      ☐Shortness of Breath ☐Chest Pain ☐Severe Coughing ☐COPD
   E. ☐Seizures ☐Convulsions ☐Epilepsy ☐Fainting ☐Dizziness
   F. ☐Bleeding Disorder ☐Anemia, Sickle Cell Disease ☐Bleeding Tendency ☐Blood Transfusion?
      ☐Do you bruise easily?
   G. Liver Disease (☐Jaundice ☐Hepatitis)? Y☐ N☐
   H. Kidney Disease? Y☐ N☐
   I. Diabetes? Y☐ N☐
   J. Thyroid Disease? Y☐ N☐
   K. Arthritis? Y☐ N☐
   L. Stomach Ulcers or Colitis? Y☐ N☐
   M. Glaucoma? Y☐ N☐
   N. Osteoporosis? Y☐ N☐
   O. Implants placed anywhere in your body Y☐ N☐ (☐Heart Valve ☐Pacemaker ☐Hip ☐Knee)?

< PREVIOUS

NEXT >

Name: **Birthdate:**

P. Cancer? Y☐ N☐

What type or treatment?____________________

Radiation to Head and Neck for Cancer Treatment? Y☐ N☐

Q. Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grind or clench teeth? Y☐ N☐

R. Sinus or Nasal problems? Y☐ N☐

S. Any disease, drug, or transplant operation that has depressed your immune system? Y☐ N☐

9. ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics? Y☐ N☐

B. Anticoagulants (Blood Thinners)? Y☐ N☐ (if yes recent INR____/ Date__________)

C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y☐ N☐

D. High Blood Pressure medications? Y☐ N☐

E. Steroids (Cortisone, etc.)? Y☐ N☐

F. Tranquilizers Y☐ N☐

G. Insulin or Oral Anti-Diabetic drugs? Y☐ N☐

H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y☐ N☐

I. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? Y☐ N☐

J. Are you/have you taken any illicit/street drugs? Y☐ N☐

(These drugs may interact with drugs/injections given by Dr. Kim causing severe adverse reaction or death).

K. Are you currently under a doctors order or taking any medication(s) including birth control pills, over the counter drugs, herbal supplements, or homeopathic prescriptions? Y☐ N☐

L. Have you ever taken Cortisone, Predisone, or Steroids? Y☐ N☐

M. Please list any and all medications you are taking on intermittent or full-time basis:

10. Do you smoke or chew Tobacco?____________________Y☐____N☐ How much per day?_______

11. Is there any past or present history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y☐ N☐

12. Have you ever had serious problems associated with any previous dental treatment? Y☐ N☐

13. Have you or an immediate family member had any problem associated with intravenous anesthesia or general anesthesia? Y☐ N☐

14. Do you have any other disease, condition, or problem not listed above that you think Dr. Kim should know about? Y☐ N☐

15. Do you wish to talk to Dr. Kim privately about anything? Y☐ N☐

16. FOR WOMEN ONLY

A. Are you pregnant, or <u>is there any chance</u> you might be pregnant? Y☐ N☐

B. Are you nursing? Y☐ N☐

C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle or birth control pills, after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

I understand the importance of a truthful Health History to assist Dr. Kim in providing the best care possible. I have had the opportunity to discuss my Health History with Dr. Kim. I grant the right to Dr. Kim to release health information obtained from me and information about my dental treatment to third party payers, and/or other health practitioners.

Signature of Person Completing Health History	Date
Patient Signature (legal guardian)	Date

FINANCIAL POLICY

Financial Policy
It is our hope you will understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain this vital health care service for our patients and the community. Full payment is due at the time services are rendered.

Insurance
If you have insurance, all co-pays will be due at time of service. This is the portion your insurance does not cover. Any remaining balances after the insurance pays will be due upon receipt of a statement from our office. Our office will assist in the filing of the insurance claims for you as long as you provide the office with all the correct billing information. If we are unable to verify coverage, you will be responsible for your bill that day.

We will do all we can to help you to help you get the benefits you are entitled to through your insurance company. Please review your insurance policy prior to treatment in order to be aware of coverage and limitations. However, if a problem arises with payment from your insurance company, you are responsible for your balance after 60 days.

Our office does not participate with Blue Cross Blue Shield Medical policies. We are currently not accepting any new adult Medicaid policy holders.

Fees
Payment can be made by cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

DRUG INTERACTION AND YOUR ORAL SUGERY TREATMENT

If you are scheduled for a procedure please be aware there will be a review of your medical history and x-ray, Dr. Kim may deem due to complexity or health issues that your first visit will be a consultation only.

Medications your surgeon uses in routine oral surgery may interact with both prescription and illegal street drugs. These reactions may result in SEVERE reactions under anesthesia which could cause harm or death. It is extremely important that you inform your surgeon of any drugs you are currently using or may have taken so this may be considered in your oral surgery planning. This information will be held in strict confidence.

The effectiveness of BIRTH CONTROL pills significantly decreases when taken with antibiotics. If you are using birth control pills and receive a prescription for antibiotics from Dr. Kim, be sure to supplement your birth control pills with an alternative contraceptive.

I have read, agree, and understand the above statement.

____

Responsible Party Signature

NOTICE OF PRIVACY POLICIES
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. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE HIPPA PRIVACY OFFICER IDENTIFIED BELOW.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive in this office. We need this record to provide you with quality care and services to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:
(1) make sure that medical information that identifies you is kept private;
(2) give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
(3) follow the terms of the Notice that is currently in effect.

HOW THIS OFFICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:
The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclosed your medical information will fit within one of these general categories:

FOR TREATMENT. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive at this office may billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a plan will cover the treatment.

FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

APPOINTMENT REMINDERS. We may use and disclose medical information to contact your as a reminder that you have an appointment for treatment or medical care at this office.

TREATMENT ALTERNATIVES. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HEALTH-RELATED BENEFITS AND SERVICES. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

RESEARCH. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

AS REQUIRED BY LAW. We will disclose medical information about you when required to do so by federal, state, or local law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

HEALTH OVERSIGHT ACTIVITIES. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

LAW ENFORCEMENT. We may release medical information about you if required by law when asked to do so by a law enforcement official.

CORONERS AND MEDICAL EXAMINERS. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

USES AND DISCLOSURES REQUIRING AN AUTHORIZATION

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time, except to the extent that we have acted in reliance of it. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. The following are examples of uses and disclosures requiring an authorization:

MARKETING. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes, except if the communication is in the form of: (A) a face-to-face communication made by us to you; or (B) a promotional gift of nominal value we provide. If the marketing involves direct or indirect remuneration to us from a third party, the authorization must state that such remuneration is involved. If the marketing involves financial remuneration to us from a third party, the authorization must state that such remuneration is involved.

SALE OF PHI. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization. Such authorization must state that the disclosure will result in remuneration to the covered entity.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

Your have the following rights regarding the medical information this office maintains about you:

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing to HIPAA Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such review contact the HIPPA Privacy Officer.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your records be sent to you or to another individual entity. We may charge you a reasonable cost based fee limited to the labor cost associated with transmitting the electronic health record.

RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office.

To request an amendment, your request must be made in writing and submitted to the HIPPA Privacy Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you as us to amend information that:

(a) Was not created by us; (b) Is not part of the medical information kept by this office; (c) Is not part of the information which you would be permitted to inspect and copy; or (d) Is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. We are not required to list certain disclosures, including disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health operations; however if these disclosures were made through an electronic health record, you have the right to request, beginning on dates established by law or regulation, and accounting for such disclosures that were made during the previous 3 years. To request this accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must state a time period which may not be longer that six years and may not include dates before April 14, 2003.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to your request for restriction, except as noted below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We are required to agree to your request for a restriction if, except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the medical information pertains solely to health care item or service for which we have been paid out of pocket in full.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer. We will accommodate all reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, your are still entitled to a paper copy of this Notice.

RIGHT TO RECEIVE NOTICE OF DISCOVERY OF A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION. We are required to notify you of any breach of unsecured protected health information concerning you following the discovery of the breach when required by regulation.

REVISIONS TO THIS NOTICE

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the office we will offer you copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact:

HIPPA Privacy Officer (269) 429-7122
John M. Kim DMD PC
3102 Niles Road St Joseph MI 49085

All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

PRINT
FORMS