HONG ORTHODONTICS

www.drjustinhong.com

Welcome

We would like to welcome you to our office.
Our goal is to make your visit pleasant and educational.
Please do not hesitate to ask all your questions.
We strive to create beautiful smile that lasts a lifetime.

PATIENT INFORMATION

Date: _____

Patient's Name _____ *Last* _____ *First* _____ *Middle*

Address _____ *Street* _____ *City* _____ *State* _____ *Zip*

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient: _____ *Email Address* Responsible Party: _____ *Email Address*

RESPONSIBLE PARTY INFORMATION

Name _____ *Last* _____ *First* _____ *Middle* _____ *Marital Status*

Residence _____ *Street* _____ *City* _____ *State* _____ *Zip*

Mailing Address _____ *Street* _____ *City* _____ *State* _____ *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____ *Street* _____ *City* _____ *State* _____ *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ *Last* _____ *First* _____ *Middle* Relationship to Patient _____

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? ○ Yes ○ No If Yes, please continue: _____

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone: _____ Relationship to Patient: _____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

Has patient had previous orthodontic treatment? Please describe:

What type of braces would like? ◯ No Preference ◯ Metal ◯ Invisalign

◯ Clear/Ceramic ◯ No Preference ◯ Other:

Have there been any injuries to the face, mouth, teeth or chin? ◯ Yes ◯ No

Chipped or injured primary or permanent teeth? ◯ Yes ◯ No

Has patient ever been informed of any missing or extra permanent teeth?

◯ Yes ◯ No

Has patient ever experienced pain/tenderness in his/her jaw joint(TMJ/TMD)?

◯ Yes ◯ No

Patient's Physician:

Phone #:

Is patient currently under the care of a physician? ◯ Yes ◯ No

Please list all drugs, including over-the-counter medications that the patient is currently taking:

Please list all drug that the patient is allergic to:

Does patient have any of the following Habits?

◯ Y ◯ N	Thumb / Finger Sucking	◯ Y ◯ N	Mouth Breathing
◯ Y ◯ N	Lip Sucking/Biting	◯ Y ◯ N	Speech Problems
◯ Y ◯ N	Clenching/Grinding Teeth	◯ Y ◯ N	Nail Biting
◯ Y ◯ N	Tongue Thrust		

For patient under 18 only:?

Has puberty begun? ◯ Y ◯ N

Has menstruation begun? ◯ Y ◯ N

How does patient feel about orthodontic treatment?

MEDICAL HISTORY

Has patient experienced any of the following medical problems?

◯ Y ◯ N	Arthritis/Joint problems	◯ Y ◯ N	Cerebral Palsy
◯ Y ◯ N	Allergies to Plastic	◯ Y ◯ N	Hemophilia
◯ Y ◯ N	Allergies to Latex/Metals	◯ Y ◯ N	Abnormal Bleeding
◯ Y ◯ N	Diabetes	◯ Y ◯ N	Convulsions/Epilepsy
◯ Y ◯ N	Rheumatic Fever	◯ Y ◯ N	HIV +/AIDS
◯ Y ◯ N	Heart Murmur	◯ Y ◯ N	Herpes, Syphilis, STD
◯ Y ◯ N	Congenital Heart Defect	◯ Y ◯ N	Kidney/LiverProblems
◯ Y ◯ N	Immune system problems	◯ Y ◯ N	Cleft Lip/Cleft Palate
◯ Y ◯ N	Hospitalizations	◯ Y ◯ N	Handicaps/Disabilities
◯ Y ◯ N	Asthma	◯ Y ◯ N	Hearing Impairment
◯ Y ◯ N	Hepatitis	◯ Y ◯ N	Emotional Problems
◯ Y ◯ N	Tuberculosis	◯ Y ◯ N	Endocrine Problems
◯ Y ◯ N	Mononucleosis	◯ Y ◯ N	Nutritional Problems
◯ Y ◯ N	Cancer	◯ Y ◯ N	Thyroid Disease
◯ Y ◯ N	Osteoporosis	◯ Y ◯ N	Fainting or Dizziness

◯ Y ◯ N Has your child ever taken oral or intravenous bisphosphonates for bone disorders or cancer?

◯ Y ◯ N Do you take antibiotic pre-medication before any dental procedures?

◯ Y ◯ N Have you noticed any unusual changes in your child's face or jaws?

Please discuss any medical problems that the patient has had:

RELEASE AND WAIVER

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in patient's medical status. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical health. I authorize the dental staff to perform any necessary dental/orthodontic services I or my child need.

Date

Signature of Patient, Parent or Guardian

Health History Reviewed By: Date

Justin S. Hong D.D.S.

MEDICAL HISTORY UPDATE

Any changes in your patient's health status? ◯ Yes ◯ No	*Comments*	*Patient, Parent or Guardian Signature*	*Date*	*Dr. Hong*
Any changes in your patient's health status? ◯ Yes ◯ No	*Comments*	*Patient, Parent or Guardian Signature*	*Date*	*Dr. Hong*
Any changes in your patient's health status? ◯ Yes ◯ No	*Comments*	*Patient, Parent or Guardian Signature*	*Date*	*Dr. Hong*
Any changes in your patient's health status? ◯ Yes ◯ No	*Comments*	*Patient, Parent or Guardian Signature*	*Date*	*Dr. Hong*

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/2/2016 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 applicable law. We reserve the right to make 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 and make the new 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person´s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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 use or 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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 may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (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 $15 for each page, $20 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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 be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Contact Officer: Justin S. Hong
Telephone: 714-744-2828_ Fax: 714-744-2829
E-mail: hongortho@gmail.com
Address: 665 N. Tustin St. Suite U, Orange CA 92867

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Patient #: _____ Social Security#: _____

SECTION B: 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 our 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 disclosures 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 the 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 any revisions of our Notice, at any time by contacting:

Justin S. Hong DDS, MS
665 N. Tustin St. Ste # U&V
Orange, Ca 92867
Telephone: (714) 744-2828 Fax: (714) 744-2828

Right to Revoke: You will have the right to revoke this Consent at anytime 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 consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

DATE _____

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

Personal Representative´s Name _____

Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient´s chart.

REVOCATION OF CONSENT

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

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

DATE _____

Submit