Allison Jung Family Dentistry

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New Patient Registration

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Relationship to person filling out form

◯ Self ◯ Spouse ◯ Parent/Guardian

Responsible Party Information

☐ **If the responsible party is the same as the patient you can skip this and go on to the next section.**

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Do you have secondary insurance coverage?
If yes, please see the receptionist ◯ Yes ◯ No

Who should we contact in case of emergency? (Name and phone number)

_____

_____

Whom may we thank for referring you?

_____

Medical History

Do you have any of the following:

Active tuberculosis, a persistent cough (greater than three weeks), a cough that produces blood, or have you been exposed to anyone with tuberulosis? If yes, please stop and see our receptionist. *

◯ Yes ◯ No

Any heart or medical condition that a physician has recommended antibiotic prophylaxis for? ◯ Yes ◯ No

Condition:

_____

_____

Previous infective endocarditis (heart infection)? ◯ Yes ◯ No

Any prosthetic heart valves, prosthetic material used for heart repair (not including stents), cardiac transplant with valve regurgitation, congenitial heart disease (unrepaired cyantoic congenital heart disease, repaired congenital heart defect with residual shunts or valvular regurgitation at or near site of prosthetic material)?

◯ Yes ◯ No

Any artificial joint(s)? * ◯ Yes ◯ No

If yes, Joint(s) and Date(s) done, Any Complications or have they been redone (yes or no, if yes please explain):

_____

_____

Name and phone number of Orthopedic Surgeon:

_____

_____

Did orthopedic surgeon recommend premed before any dental appointments?

☐ Yes ☐ No ☐ Not Sure

Are you now under the care of a physician for anything other than routine or preventive care? * ◯ Yes ◯ No

Physician Name and Phone Number:

_____

_____

Please mark your response to indicate having any of the following diseases or conditions: *

☐ Cardiovasular disease	☐ Diabetes Type I or II	☐ Angina	☐ Arteriosclerosis
☐ Congestive heart failure	☐ Heart attack	☐ Heart murmur	☐ Low blood pressure
☐ High blood pressure	☐ Congential heart defect	☐ Mitral valve prolapse	☐ Pacemaker
☐ Rhuematic fever	☐ Abnormal bleeding	☐ Anemia	☐ Hemophilia
☐ AIDS/HIV infection	☐ Arthritis	☐ Autoimmune disease	☐ Rheumatoid arthritis
☐ Systemic Lupus Erythematous	☐ Asthma	☐ Bronchitis	☐ Emphysema
☐ Sinus trouble	☐ Cancer / chemo / radiation	☐ Chronic pain	☐ Malnutritiun
☐ Gastrointestinal disease	☐ Reflux / persistant heartburn	☐ Ulcers	☐ Thyroid condition
☐ Stroke	☐ Glaucoma	☐ Hepatitis	☐ Jaundice or liver disease
☐ Epilepsy	☐ Fainting spells or seizures	☐ Neurological disorder	☐ Sleep disorder
☐ Do you snore?	☐ Mental health disorder	☐ Recurrent infections	☐ Kidney problems
☐ Night sweats	☐ Osteoporosis	☐ Persistant swollen glands in neck	☐ Severe headaches / Migraines
☐ Severe or rapid weight gain / loss	☐ Sexually transmitted disease	☐ Exessive urination	☐ No known medical conditions

Do you have any disease, condition or problem not previously listed that you think we should know about? ◯ Yes ◯ No

If yes, please list:

_____

_____

Are you currently taking any prescription medications or over the counter medications? * ◯ Yes ◯ No

If yes, please list all including vitamins, herbal and or dietary supplements and the condition taken for (i.e. lisinopril for high blood pressure)

_____

_____

Allergies: Are you allergic or have you had a reaction to any of the following (to all checked responses, specify type of reaction at bottom):

*

☐ Local Anesthetics	☐ Aspirin	☐ Penicillin or any other antibiotic
☐ Barbiturates, sedatives or sleeping pills	☐ Sulfa drugs	☐ Codeine or other narcotics
☐ Metals	☐ Latex (rubber)	☐ Iodine
☐ Foods	☐ Nitrous Oxide	☐ No known allergies
☐ Other		

Explanation of reaction or Other allergy not listed above:

_____

_____

Have you previously taken, are taking, or scheduled to begin taking in any form including intravenously, a bisphosphonate or similar medication including but not limited to: Fosamax, Actonel, Evista or Prolia for any condition(s) including but not limited to: osteoporosis, bone pain, complications of Pagets diesease, multiple myeloma or metastatic cancer? *

◯ Yes ◯ No

If yes, please list which medication, what form (i.e. oral) and date treatment began and ended:

Women Only: Are you

Pregnant ◯ Yes ◯ No

Number of weeks/Due Date? _____

Taking birth control pills or hormone replacement? ◯ Yes ◯ No

If yes, what?

Nursing? ◯ Yes ◯ No

*****Please refrain from alcoholic beverages and non medically prescibed drugs at least 12 hours prior to dental treatment*****

Are you or have you used tobacco products, including smokeless tobacco or snuff? * ◯ Yes ◯ No

If yes please specify Product(s) (i.e. cigarettes), Amount (i.e. 1 ppd), and Duration (i.e.5 years):

Are you or have you used drugs including controlled substances and marijuana? * ◯ Yes ◯ No

Do you drink alcoholic beverages? ◯ Yes ◯ No

Dental Health History

Previous Dentist Name, Address and Phone Number:

Date of last dental appointment and x-rays taken? _____

Reason for today's visit?

Dental Information: please mark all that apply to you *

☐ Bleeding gums when brushing or flossing	☐ Teeth sensitivity to cold/hot, sweets, pressure	☐ Food/Floss catching between your teeth
☐ Dry mouth	☐ Prior/Current Periodontal (gum) treatment(s)	☐ Prior/Current orthodontic (braces) treatment
☐ A splint or night guard	☐ Denture(s) or Partial(s)	☐ Issues with previous dental treatment
☐ Current dental pain or discomfort	☐ Headaches, earaches or neck pain(s)	☐ Clicking, popping or discomfort in the jaw
☐ Grinding your teeth	☐ Sores/Ulcers in your mouth	☐ Participate in active recreational activities
☐ Previous serious injury to your head or mouth	☐ Anxiety or fear of dental treatment	☐ Preference for nitrous oxide (laughing gas)
☐ Unhappy with the appearance of your teeth	☐ Sleep Apnea Appliance	☐ No dental concerns

General Consent

I consent to the diagnostic procedure and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

My consent to the disclosure of the records shall be effective until I revoke it in writing.

I authorize payment directly to Allison Jung Family Dentistry, PLLC or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or Payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is a valid and the original.

Signature _____ **Date** _____

☐ * **I have read the information above regarding the secured uploading of patient information and grant the dental practice permission to securely upload my patient information to the server. This will serve as my electronic signature.**

Financial Policy

Welcome to the office of Allison M. Jung, D.D.S. Please take a few minutes to review the following information prior to your appointment. We hope that you understand that our financial policies are established to assure the financial resources needed to maintain this dental office for all our patients.

Please arrive at least 10 minutes prior to your appointment to give yourself plenty of time to update your records or complete paperwork required. To meet the needs of all our patients, please call us immediately if you must re-schedule your appointment so we can accommodate other patient's needs. If you fail to cancel or re-schedule within 24 hours of your dental appointment, you will be billed $50.00 for that missed appointment.

Charges for dental services are due and payable at the time of services. We accept cash, personal checks, most major credit cards, care credit for payment on your account.

If you have dental insurance:
Your insurance is an agreement between you and your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

As a courtesy to our patients, we will file insurance claims with all insurance carriers; the patient is responsible to pay any deductibles or co-pays at the time of services.
All unpaid balances over 45 days are subject to an 18% APR finance charge. All accounts over 90 days past due will be referred to a collection agency and you will be responsible for all legal fees/charges incurred. Under these circumstances, it is possible that you will no longer be seen as a patient in this office.

By signing below, the patient authorizes the exchange of information relating to care and claims with the patient's insurance company(s) and authorizes payments to be made directly to the practice for services provided under the insurance agreement and otherwise payable to the patient. If you have any further questions concerning the financial policy of this office, please do not hesitate to ask. We are happy to work with patients to ensure that their dental care is the finest available.

Thank you for understanding.

Signature _____ **Date** _____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the 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 make 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 health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject for the federal Privacy Rules of its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that it subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. You revocation will not affect any uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgement of whether the disclosure would be in your best interest. We may use our professional judgement and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, or your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:
- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting times in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer, we may - but are not required to- prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of the registration paperwork for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information since April 14, 2003. That list will include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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 restrictions 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 emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreeing is in writing.

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. You must specify in your request that alternative means or location and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the top of this form.
If you believe that:
1. We may have violated your privacy rights;
2. We made a decision about access to your health information incorrectly;
3. Our response to a request you made to amend or restrict the use or disclosure of your health information is incorrect, or;
4. We should communicate with you by alternative means or that alternative locations, you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIPAA Policy

- I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures.

- I agree that the practice may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

-The practice may leave a detailed phone message at the following listed numbers below regarding my dental or billing information.

Disclosures to Friends and/or Family members: I give permission for my (or my child's) protected dental/health information to be disclosed for purposes of billing and payment, communicating results, findings and care decisions to the people designated below. Information will not be released without authorization, even to family members.

Please list full Name, Relationship, and Contact Number:

_____

_____

I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to all information and statements.

Signature _____ **Date** _____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Prescription Drug Monitoring Notification

By signing this form, you confirm that you have been notified that if you received a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances- like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants, or any other category of prescription drug for you.

Only authorized individuals, like healthcare personnel that prescribes controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be a reason to be concerned. If you do not want your information in the database, please ask your dentist to prescribe a non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program can be obtained from the Colorado State Department of Regulatory Agencies by calling 303-894-5957 or by visiting: http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm

Signature _____ **Date** _____

☐ * **By checking this box, I acknowledge that I have read the above Prescription Drug Monitoring Notification and agree to the contents.**

If this notification is signed by a personal representative on behalf of the patient, please print name and relationship to patient:

_____

_____

Release of Previous Records

To Allison Jung Family Dentistry
1927 Wilmington Dr., Ste 202
Fort Collins, CO 80528
Phone:970-484-4850, Fax:970-484-2757
info@ajfamilydentistry.com

***For best diagnosis and treatment, please contact your previous dental office for release of your x-rays and records to be emailed or faxed to the location at the top of this form. Or sign this form at least 3 days prior to your appointment.**

I authorize the release of: *

☐ Current bitewing, Full Mouth or Panoramic X-rays ☐ Dental Treatment Notes

For Patient: _____

Previous Dentist Name, Address and Phone Number:

_____

_____

_____

Signature _____ **Date** _____

☐ * **By checking this box, I give consent for this office to contact my previous dentist to retrieve above marked information.**

Response Date: ____/____/_____