DAYTON DENTAL
FAMILY DENTISTRY

2020 S. Parker Rd. Ste F. Denver.Colorado.80231
Office|720.477.1449 Fax|720.484.8948

OUR OFFICE POLICIES

Welcome to Dayton Dental! We are pleased to have you as a patient and to be given the opportunity to be your partner in informed dental health care. Our office policies are designed with you, the patient, in mind. It is written to answer any questions you may have regarding how our office works.

1. **Appointments**
   We are committed to providing a high standard of personalized dental care in an efficient and professional manner. Our office is open Monday through Friday, from 8:00am until 5:00pm, and Saturdays on appointment basis. A one-hour lunch break is normally taken and does vary as scheduled based upon our patients' needs for the day. We value the time our patients set aside for their dental needs; therefore, we request that patients notify us of cancellations or reschedule 24 hours prior to the scheduled dentist appointments. This allows our office to meet dental needs of other patients who are waiting for care. If an emergency occurs, as often do, and a patient is unable to attend their appointment, our office kindly requests communication that the dentist appointment will be missed and rescheduled. We understand how valuable your time is and our office strives to accommodate your scheduling needs.

2. **Cancellations**
   We request a 24-hour notice if you need to cancel or reschedule your appointment. We understand that sometimes unforeseen events require missing an appointment. However, after your second appointment canceled without notifying us 24 hours in advance, or the second time you are more than 15 minutes late, you will be subjected to a $50 "missed appointment fee". If you were scheduled more than an hour, a $25 additional charge per half hour will be charged.

3. **Late Policy**
   Your appointment has been reserved specifically for you. Please arrive on time for your appointment or 15 minutes early if it is your first appointment to fill out paperwork. If you are more than 15 minutes late, you may be asked to reschedule.

4. **Emergencies**
   Dayton Dental is closed on Saturdays (if no appointment is scheduled), Sundays, and major holidays. If you have a dental emergency, please call our office as soon as possible. We will try our best to accommodate your needs. If you have an after-hours emergency, please call our office at (720)477-1449 and leave a voicemail which will be forwarded to Dr. Dale Kim and Dr. Michelle Noh.

5. **Insurances**
   For your convenience, we will gladly assist you in submitting insurance claims regarding charges for care rendered in our office. However, due to the complexities of insurance contracts, we can only give you an estimate of what your portion will be and cannot guarantee your insurance coverage. Your estimated patient portion must be paid at the time of service. We will give your insurance 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full for all payment not covered by your insurance company. If you have any questions, our staff is always available to answer your questions or concerns.

6. **Timeliness of payment**
   You are responsible for deductible and estimated co-payments at the time of service. If there is any balance left after your insurance paid your claim, we will either call and ask you to provide a payment or mail a statement to your address. The full balance is expected within 14 days. Accounts 60 to 90 days delinquent will be sent to collections and further fees will be applied appropriately.

As witness by my signature, I hereby acknowledge I have been advised of the Office Policies of Dayton Dental.

Patient Name: _____Signature:_____ Date:_____

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PATIENT REGISTRATION

TODAY'S DATE: _____/_____/_____

GETTING TO KNOW YOU

How did you find us?

_____

(*If it was another patient of ours that referred you to us, please list their name here so we can thank them, thank you!*)

Name:_____
(First) (Middle) (Last)

Phone numbers: 1. ( )- - 2. ( )- - 3. ( )- -
Home Cell Work

Email:_____ Date of Birth: _____
MM/DD/YYYY

Address:_____
Street Address City State Zip

SSN:_____ ←(ONLY for insurance purposes and will be kept strictly confidential)

Emergency Contact: Name_____ Phone( )- - Relationship_____

INSURANCE INFORMATION (Please provide a copy of your insurance card.)

Do you have dental insurance?.....YES_____NO_____

If YES,

Insurance Name:_____Policy Number:_____ Group Number:_____
(i.e. Aetna, Cigna, etc.) (Member ID)

Are you the plan subscriber?.....YES_____ NO_____

If NO,

Subscriber Name:_____ DOB:_____ SSN:_____Relationship:_____
MM/DD/YYYY (To Patient)

Dental & Medical History Form

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Name: _____ DOB: _____ Date: _____

Are you completing this form for another person?..... NO___ YES ___

If YES, Your Name: _____Phone #: _____Relationship to patient: _____

Do you have…?

Active Tuberculosis..... NO____ YES____

Persistent cough (lasting longer than 3 weeks) ..... NO___ YES____

Cough that produces blood?..... NO___ YES ____

Have you been exposed to anyone with Tuberculosis?.....NO___ YES___

If you answered YES to any of the items above, please stop and return this form to receptionist, Thank You.

DENTAL HISTORY:	**(Check YES or NO or DK if you Don't know)**
Reason for today's visit?	_____
Do you have any dental related pain?	NO YES (if yes what kind of pain?) _____ _____
When was your last visit to the dentist?	_____
Ever received periodontal (gum) therapy?	NO ___ YES ___ DK ___
Any persistent dry mouth concerns?	NO ___ YES ___ DK ___
Is your water supply fluoridated?	NO (Well or Rural) ___ YES (City Water) DK ____
Have you ever had orthodontic(braces) treatment?	NO ____ YES ____ DK ____
Do you have earaches or neck pain?	NO ____ YES ____ DK ____
How do you feel about your smile?	_____
Have you experienced Mouth odors or bad taste?	NO ____ YES ____ DK ____
Have you experienced Bleeding or painful gums?	NO ____ YES ____ DK ____
Have you experienced loose teeth or change in bite?	NO ____ YES ____ DK ____
Do you Clench or Grind your teeth?	NO ____ YES ____ DK ____
Do you have tired/sore jaws especially in the morning?	NO ____ YES ____ DK ____
Do you drink coffee or tea?	NO ____ YES ____ DK ____
Are you interested in bleaching/whitening?	NO ____ YES ____ DK ____
Are you nervous about dental treatment?	NO ____ Yes _____ (if yes what is your biggest concern?) _____
Do you take pre-medication prior to dental treatment?	NO ____ YES ____ (if yes, what do you take?) _____ _____
MEDICAL INFORMATION:	**(Check YES or NO or DK if you Don't know)**
Are you in good health?	NO ____ YES ____ DK ____
Has there been any changes in your health within the past year?	NO ____ YES ____ DK ____
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	NO ____ YES ____ DK _____ (if yes, what was it _____ date of surgery ___/___/_____
Do you smoke or use tobacco products regularly?	NO ____ YES ____ DK _____ Are you interested in quitting? NO _____ YES _____
Do you use any recreational drugs?	NO ____ YES ____ DK _____
Do you drink alcohol?	NO ____ YES ____ Number of Drinks/Week _____

FOR WOMAN ONLY:	(Check YES or NO or DK if you Don't know)
Are you pregnant?	NO __YES ___DK ___If yes: How many weeks are you? _____
Are you taking birth control/hormone replacement?	NO ____ YES ____ DK ____
Are you nursing?	NO ____ YES ____ DK ____

The following information is essential for the safe and effective diagnosis and treatment of each patient.

Do you have or had any of the following?	(Check YES or NO or DK if you Don't know)
Congenital Heart Disease/Heart Murmur/Rheumatic Fever…….. NO ____ YES ____ DK ____	Breathing problem (Sleep Apnea, Emphysema, Shortness of Breath, Oxygen Dependent, Cough) ……. NO__YES __DK __
Heart Attack ……NO ___ YES ____ DK ____	Irregular Heartbeat …. NO___ YES ____ DK ___
Angina/Chest pain ……. NO ____ YES ____ DK ___	Heart Surgery…… NO ____ YES ___ DK ___
Artificial Heart Valve …. NO ____ YES ___ DK ___	Heart Pacemaker…. NO ____ YES ___ DK ____
High Blood Pressure ……NO ____ YES ___ DK ___	Low Blood Pressure….NO____ YES___ DK____
Stroke/Paralysis……. NO ____ YES____ DK ___	Asthma……NO ____ YES ___ DK ____
Tuberculosis ……NO ____ YES ___ DK ___	Kidney Disease …… NO ___ YES ___ DK ____
Liver Disease/Yellow Jaundice...NO___YES___DK___	Stomach/intestinal disease/ulcers… No__ YES __ DK ___
Convulsions/Seizures/Epilepsy….NO __YES __DK ___	Numbness or tingling/Back pain …. NO__YES__DK__
Fainting/Dizziness…….NO___ YES___ DK____	Diabetes Type 1 or 2 …. NO ___ YES___ DK ___
Steroid Treatment (Cortisone) NO___ YES___DK___	Blood Disorder/Bruising easily NO___ YES__DK__
Immune System (Lupus, Immunodeficiency, Sjogren) NO__YES__DK__ Herpes….NO___YES___DK___	HIV/Aids…. NO___ YES___DK____ Hepatitis A, B or C … NO___ YES___DK____
Arthritis/Pain in joints … NO ___ YES____ DK___	Artificial Joint…. NO____YES___DK_____
Osteoporosis/Bisphosphonate Therapy (Boniva, Fosamax, Zometa, etc.) NO___ YES___DK___	Current Cancer…. NO___YES___DK____ Past Cancer… NO___YES___DK____
Radiation Therapy ..NO___YES___DK____	Chemotherapy NO___YES___DK____
Recent Weight Gain/Loss … NO___YES___DK___	Drug/Alcohol treatment…NO___YES___DK___
Difficulty Hearing….NO____YES____DK____ Hives/Rash….NO___YES___DK___	Eye problems (Dry eyes/Glaucoma) …… NO___YES__DK___

Any Other Medical Condition not listed above?	_____ _____.
Have you been hospitalized in the past year?	**NO ___ YES___DK___ If yes- what were you treated for? _____ _____.**
Have you experienced an unusual or allergic reaction to any of the following?	**__ Local Anesthetic __Codeine __Penicillin __Narcotics __ Sulfa Drugs __ Latex Rubber __ Aspirin __ Metals __ Hay Fever/Seasonal __ Animals __ Iodine __ Other If other, please describe: _____ _____.**
Please list the Medications you are currently taking (including over the counter, or supplements or Herbals including dosage……	_____ _____ _____.

NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____Date: ____/____/_____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. Dayton Dental recognizes our obligation to protect the privacy of health information that we create, receive, maintain, or transmit. We are committed to protecting your health information. We create record of the care and services you receive at our offices. We need this record to provide you with quality care to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff. This notice will tell you about the ways we may use and disclose your health information. We also describe rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:

1. Ensure that health information that identifies you is kept private;
2. Give you this notice of our legal duties and private practices with respect to health information about you; and
3. Follow the terms of this notice that is currently in effect, as we may change it from time to time.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment: We may use your health information to provide you with dental treatment or services. We may disclose health information about you to dentist, dental assistants, hygienists, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider, or your dentist may need to disclose health information to people outside the office who may be involved in your dental or health care after you leave the dental office, such as family members.

For payment: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third-party payer. For example, we may need to give your dental/health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose your health information for office operations. These uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff but are not employees of the office. We may also combine health information about may of our patients to decide what additional services we should offer and what services are not needed. We may also combine health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Individuals Involved in Your Care or Payment: We may disclose your health information to a member of your family, your friend or another individual who is directly involved in your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to a family member, friend, or other individual to health-related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions or post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We may also give information to someone who helps pay for your care. We will not make these disclosures to your friends and family if you tell us not to.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers Compensation: We may release your health information for workers' compensation or similar programs, these programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, however, if you do not consent release of information, your workers' compensation benefits may be denied, and you will be responsible for the costs of your dental care.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect, fugitive, material witness or missing person. About a victim of a crime if under certain limited circumstances, we are unable to obtain the persons' agreement about a death we believe may be the result of criminal conduct, about a criminal conduct at the hospital and in an emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

Permission from you: Other uses and disclosures of health information not covered in the above categories will be made only with your permission. You may give permission with a written consent or authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission at any time orally or in writing. If you revoke permission, we will no longer use or disclose health information about you to the extent your permission is needed for the use or disclosure. You understand that we are unable to take back any disclosures we have already made with your permission and that we required to retain our records of the care that we provided to you.

Your Health Information Rights.

You have the following rights concerning health information we maintain about you:

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information if you make a request in writing by completing our records authorization form and you will be provided the information and copy of records within 72 hours after the administrative fee and authorization form are completed. If you want to inspect, copy or receive this information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. If you request copy of your health information, we will charge you a fee for the costs of copying, mailing, compiling and/or printing your request or of preparing a written summary or explanation, as well as for administrative fee that will cover labor costs. We may deny your request in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Receive your Health Information in Electronic Form: If you make a request on or after February 17,2010 for an electronic copy of the health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you our labor costs in responding to your request.

Right to Ask for Changes in Health Information: If you feel that health information, we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the form you will need to ask for a change or addition. You must give us a reason for your request. We may deny your request for a change or addition to your health information if it is not in writing or does not include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that: we did not create, unless the person or entity that created the information is no longer available to make the change or addition, is not part of the health information kept by the office, is not part of the information which you would be permitted to inspect and copy or is already accurate and complete.

Right to Request Restrictions: You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. We do not have to agree to the restrictions that you request, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us: what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply(for example, your spouse, your children, your parents or others involved in your care). To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer for our office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location. 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 privacy officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all responsible requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

Right to be Notified of Breach of Security: You have the right to be notified if there is a security breach with respect to your protected health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as posting to our website or notices in print or broadcast media.

Changes to this Notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. The current notice will be posted in our dental offices and we will include the effective date.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services, To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy Officer and Contact Information: Dayton Dental Privacy manager, mailing address: 2020 S. Parker Rd, Ste F. Denver, Colorado 80231. (720)477-1449.

As witness by my signature, I hereby acknowledge I have been advised of the Office polices of Dayton Dental.

Patient Name:_____ Signature:_____ Date:_____