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.

This notice is effective as of February 7, 2003

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT, PAYMENT AND HEALTH CARE OPERTIONS

Arthur Benson Choi, D.D.S. uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of a diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
- Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURES

Arthur Benson Choi, D.D.S. may also use or disclose your protected health care information, in compliance with guidelines outlined, by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery request or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies; or
- Informing a family member, other relative, or close personal friend when:
- Information is relevant to the individual's involvement with your care;
- Notification of your location, general condition or death;
- To assist in your heath care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.)

AUTHORIZATION FOR OTHER USES

Arthur Benson Choi, D.D.S. will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not not contained in this note, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of Your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, **Arthur Benson Choi, D.D.S.** is not obligated to agree to requested restrictions.
- Receive confidential communications to protect health information.
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a copy of this notice.

Arthur Benson Choi, D.D.S.

DUTIES REGARDING THE PRIVACY OF OUR HEALTH INFORMATION

Subject to limitations outlined by law, **Arthur Benson Choi, D.D.S.** has certain duties related to your protected health information, including:

- **Arthur Benson Choi, D.D.S.** is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- **Arthur Benson Choi, D.D.S.** is required to abide by the terms of the privacy notice that is currently in effect.
- **Arthur Benson Choi, D.D.S.** reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting Jessica Ramirez by mail at 16001 Comprint Circle, Gaithersburg, MD 20877 or by phone at (301) 948-0404 or the Secretary for the Department of Health and Human Services. No individual will retaliated against for filing a complaint.

Arthur Benson Choi, D.D.S.

Date: _____

Please update all information, sign and return. Thank you.

PATIENT INFORMATION		
Patient Name	Martial Status	Sex: M or F
Street Address(No PO Box's)	Home Phone #	Work Phone #
City, State, Zip	Date of Birth	Cell Phone #
Occupation	Social Security #	Driver's License #
Whom may we thank for referring you?	Email Address	

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY		
Guarantor's Last	First Name MI	Home Phone #
Address	City, State, Zip	Work Phone #
Employer	Employer's Address	

PRIMARY INSURANCE INFORMATION			
Insurance Company		ID #	Group #
Address	City, State, Zip		Phone #
Policy Holders Name	Policy Holder Date of Birth		Social Security #
Policy Holder's Employer	Patient's Rel. to Ins.	Insurance Effective Date	

SECONDARY INSURANCE INFORMATION			
Insurance Company		ID #	Group #
Address	City, State, Zip		Phone #
Policy Holders Name	Policy Holder Date of Birth		Social Security #
Policy Holder's Employer	Patient's Rel. to Ins.	Insurance Effective Date	

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Arthur Benson Choi, D.D.S.

FINANCIAL POLICY

I certified that the information I have provided regarding my insurance coverage is correct and authorize Arthur Benson Choi, DDS to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I agree to accept full responsibility for payment if my insurance coverage is not verified.

Arthur Benson Choi, DDS may impose a no show fee of $**45.00** for appointments not canceled 24 hours in advance.

I authorize that payments be made directly to Arthur Benson Choi, DDS for all dental insurance benefits which are payable under the terms of my insurance policy for the services provided.

I agree to pay any co-payments, co-insurance, or deductible as required by my insurance plan for dental care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Payment by cash, check, VISA, MasterCard, Discover or American Express is accepted. **All outstanding account balances must be paid in full with in 90 days of the date of service**. All accounts remaining unpaid after 90 days may be submitted to our debt collections attorney unless you make payment agreements. In addition the outstanding account will be subject to collection fees and interest charges of 2%* per month. You will be held responsible for all collection costs and attorney fees. A fee of $35.00 will be assessed on all returned checks.

I agree to pay for dental services provided to me or my dependent which are not covered by the benefits of my insurance plan.

Your signature below indicates that you have read and understood this notice, and that you agree to its contents.

Print Patient or responsible party Date
(Parent or guardian if patient is under 18 years old)

Signature of patient or responsible party Date
(Parent or guardian if patient is under 18 years old)

* fees and rates are subject to change

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last cleaning _____

Reason for leaving _____ Date of full mouth x-rays _____

Place a mark on '**yes**' or '**no**' to indicate if you have had any of the following:

Periodontal (gum) disease	☐ Yes	☐ No	Treatment for TMJ problems	☐ Yes	☐ No
Bleeding Gum	☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No
History of headaches	☐ Yes	☐ No	Orthodontic Treatment	☐ Yes	☐ No
Root Canal Therapy	☐ Yes	☐ No	Teeth sensitive to HOT	☐ Yes	☐ No
Grinding or clenching your teeth	☐ Yes	☐ No	Teeth sensitive to COLD	☐ Yes	☐ No

HEALTH HISTORY

Do you have Osteoporosis or any other bone disorders? ☐ Yes ☐ No

If yes, list medication(s) _____ Fusomax, Boniva, Actonel, Aredia, Zometa

Are you currently under a physician care? ☐ Yes ☐ No

If yes, why _____

Are you pregnant? ☐ Yes ☐ No

Do you need to be ***premedicated*** before a dental appointment? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much and how long? _____

Place a mark on '**yes**' or '**no**' to indicate if you have had any of the following:

Rheumatic Fever	☐ Yes	☐ No	Kidney Dialysis	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Prosthetic Joint Replacement	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting Tendency	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Asthma/Hay fever	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No	Mental Disorders	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Cancer or Tumor	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tattoos	☐ Yes	☐ No
Kidney/Bladder Trouble	☐ Yes	☐ No	Alcoholism/Drug Abuse	☐ Yes	☐ No

Any other disease, condition or problem not listed? _____

MEDICATIONS

List any medications you are currently taking

_____

_____

Physician's Name _____

Phone _____

ALLERGIES

Penicillin	☐ Yes	☐ No	Metals	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Dental Anesthesia	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Amoxicillin	☐ Yes	☐ No	Other		
Household Bleach	☐ Yes	☐ No			

The above information is true to the best of my knowledge. Consent for treatment: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Dental/Health History Form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operation as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

SIGNATURE: _____ **DATE:** _____

Patient Acknowledgement of receipt of
USES AND DISCLOSURES OF HEALTH INFORMATION

I _____acknowledge that I have received and
Printed name
reviewed a copy of the *USES AND DISCLOSURES OF HEALTH INFORMATION* forms from Arthur Benson Choi, D.D.S. regarding the use and disclosure of my health information.

Signature:_____

Date:_____