Dr. David Son DDS

17875 Von Karman, Suite #410 Irvine, CA 92614 (949) 552-0941

CONFIDENTIAL PATIENT INFORMATION -Please print legibly Referred By: _____

Name: _____ M.I. _____ Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Drivers License Number: _____ Sex: ____ Marital Status: _____ Spouse Name: _____

Occupation: _____ E-Mail Address: _____

Emergency Contact

Name: _____ Relationship: _____ Home Phone: _____

Address: _____ Cell Phone: _____ Bus. Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

D.O.B.: _____ Driver's Lic: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Bus. Phone: _____ Cell Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____

Address: _____ City: _____ State: _____ Zip _____

Employee: _____ Relationship: _____ SS# _____ D.O.B. _____

Employer: _____ Employer Phone No: _____ Policy Number: _____

Secondary Insurance Co.: _____

Address: _____ City: _____ State: _____ Zip _____

Employee: _____ Relationship: _____ SS# _____ D.O.B. _____

Employer: _____ Employer Phone No: _____ Policy Number: _____

24 hours notice is required for cancellations, to avoid a cancellation charge. I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: _____ Date: _____

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Full Name (Mr/Mrs/Miss/Ms) _____

Your Physician's Name and Address _____

ARE YOU:	YES	NO	DETAILS
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any prescribed medicines (e.g. tablets, ointments, injections, inhaler including Contraceptive or hormone replacement therapy?)			
Taking or have taken steroids in the last 2 years?			
Allergic to any medicines, foods or materials? (e.g. penicillin/latex/metals)			
Pregnant (due date)			
Had a baby within the last 12 months (delivery date)			

DO YOU HAVE OR HAVE YOU EVER SUFFERED FROM:			
Rheumatic Fever			
Any Heart Disease, surgery, Stroke or Pacemaker?			
Diabetes			
Epilepsy or fainting			
Chronic Bronchitis or Asthma			
Hepatitis (Type A B C)			
Medical warning card			
Excessive bleeding			
High Blood Pressure			
Undergone any operations within the last 2 years			
Joint Replacement			
Any Infectious Disease (including HIV)			
Any other serious illness			
Are there any other aspects concerning your health that we should know about?			

Do You:	Smoke	Drink Alcohol

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.

Please tell our staff if you have a condition that Dr. Son should be aware of. We strive to make your dental care as comfortable as possible.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Date	Patient Signature	Changes to Medical History	Dr/Hyg Initials

DAVID SON DDS
17875 Von Karman, Suite #410 Irvine,
CA 92614

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry. OZONE THERAPY and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment according to the office's financial policy.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date

Dr. David Son D.D.S

17875 Von Karman, Suite #410 Irvine, CA 92614 (949) 552-0941

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/01/2011, 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 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 made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. 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 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 restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions 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 you made 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 upon request. We support your right 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.

Contact Officer: Dona Turk
Telephone (949) 552-0941 Fax: 949-552-1205
Address: 17875 Von Karman, Suite #410 Irvine, CA 92614

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Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I, _____, acknowledge I have received from this office
Print Name

1. A copy of the Dental Materials Fact Sheet; and

2. Notice of Privacy Practices.

_____ _____
Patient Signature or Personal Representative Date

If signed by a Personal Representative of the Patient describe the representative's authority to act for the patient.

_____
_____
_____

For Office Use
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
o Individual refused to sign

o Communications barriers prohibited obtaining acknowledgement

o An emergency situation prevented us from obtaining acknowledgement

o Other (Please Specify)

_____
_____
_____
_____

David Son DDS
17875 Von Karman, Suite #410
Irvine, CA 92614
(949) 552-0941

Dr. David Son DDS

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Patient Consent for Electronic Communication

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that Dr. David Son DDS Inc. may send to you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement
I agree that the practice may electronically communicate with me at the following email address.

Email Address_____

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

Information about my invoice or accounts payable.

Information about any dental visit.

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

___√___I am responsible for providing the dental practice any updates to my email address.

___√___I am able to receive information electronically and store it securely away from any public computer.

___√___I can withdraw my consent to electronic communications by calling (949)552-0941.

Patient Name _____

Patient's Signature_____ Date_____

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Cancellation Policy/No Show Policy For Doctor And Hygiene Appointments

1. Cancellation/NoShow Policy for Doctor/Hygiene Appointment

We understand that there are times, when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be presenting another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a seventy five dollar ($75) fee;

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 3 days in advance, you will be charged a seventy five dollar times blocked hours ($75 X hrs) fee;

4. Account balances

We will require that patients with self pay balances, do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option, may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100, must make payment arrangements prior to future appointments being made.

Print Name Patient	Signature Patient/Guardian	Date

Dr. David Son DDS

17875 Von Karman, Suite #410 Irvine, CA 92614 (949) 552-0941

Welcome to our practice. One of our goals is to clearly explain treatment options, as well as any financial responsibility. Therefore, we offer the following financial arrangements. Payment is due, at the time of treatment.

1) *Cash or Check*

2) *Credit Card*
   - *a) American Express*
   - *b) Visa*
   - *c) Master Card*
   - *d) Discover*

I authorize David Son DDS Inc. to keep my signature on file and to charge my credit card for any portion not covered by my other financial arrangements.

#_____

exp._____ cvv_____

3) *Care Credit- 6 month interest free payment option **On Approved Credit ***

_____ _____

Patient Date