WELCOME

Daniel J. Lyu D.D.S.

Patient Information & Practice Agreement

We would like to extend a warm welcome to our practice, where helping you obtain a healthy, beautiful smile is what we love to do best! Our goal is to help you reach and maintain maximum oral health. We are committed to making sure your visits with us are comfortable and enjoyable. Please fill out this form completely.

Tell Us About You

_____Dr. ______Mr. ______Mrs. _____Ms.

Full Name ____

I prefer to be called _____________________________________

Who can we thank for referring you to us?

____

Birthdate _____/_____/________ ____Male ____Female

Social Security No. ____________________________________

Address ____
Apt#

____
City State Zip

E-Mail ____

Home Number ____

Cell/Other ____

Where and when is the best way to reach you?

____

Occupation ____

Employer ____

Work Number ____________________________ Ext_________

_____Single _____Married _____Divorced _____Widowed

Spouse ____

In case of an emergency, who should we contact?

Name ____

Relation to you ____

Contact Number ____

INSURANCE COVERAGE

Do you have insurance? ______ No _______Yes

Insurance Co. Name _____________________________________

Insurance ID# ________________________ Group#__________

Insured Name__________________________ Relation________

Insured DOB_________________________ SS#____________

Insured Employer _______________________________________

Dental Information

Please provide information on the last dentist you have seen:

Name ____

Phone Number ____

Last visit ____

Type of Treatment _______________________________________

What is the primary reason for today's visit?

____

____

Are you currently experiencing pain/discomfort? __Y__N

Current Dental Health: _____Good _____Fair _____Poor

Does food catch between your teeth? _____Yes _____No

Are your teeth sensitive to cold or sweets? ____Yes ___No

Do you feel your teeth are yellow or dark? ___Yes ___ No

Do you like your smile? ___ Yes ___ No

If no, what would you like to change about your smile?

____

Y	N	
__	__	Are your teeth somewhat yellowed, darkened, or stained?
__	__	Have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD)
__	__	Are there spaces between any of your teeth?
__	__	Do you grind you teeth or are any of the biting edges on your teeth chipped or worn down?
__	__	Are your gums red, puffy, or do they bleed?
__	__	Do you have any gray, black or silver dental fillings in your teeth that you want to replace?
__	__	Do you have old crowns that have dark edges at the top or that don't look natural?
__	__	Do you smoke? How much? __________________
__	__	Do you drink alcohol? How much? _____________

Medical History

Do you consider your current overall physical health:
________ Good ________ Fair _______ Poor

Are you currently under the active care of a physican or do you have any present health issues? _____Yes _____No

Please explain ___________________________________

Do you need to be premedicated with antibiotics for any heart or other conditions before dental treatment?
_____ Yes _____ No

Are you taking prescription or over the counter medication? (including ibuprofen, diet supplements etc.)
Please list each one: ______________________________
____

Are you pregnant or nursing? ______ Yes _____ No
If yes, which trimester? ______1st ______ 2nd ______ 3rd

Have you ever had any of the following illness or medical problems in the past five years?
Please answer with Yes or No

_____ Abnormal bleeding
_____ Alcohol/drug abuse
_____ Allergies
_____ Anemia
_____ Arthritis
_____ Artificial bones/joints/ valves
_____ Asthma
_____ Blood Transfusion
_____ Bone/Joint disease
_____ Bursitis
_____ Cancer/ Chemotherapy
_____ Colitis
_____ Congenital heart defect
_____ Diabetes
_____ Difficulty breathing
_____ Eating disorder
_____ Emphysema
_____ Epilepsy
_____ Fainting spells
_____ Frequent headaches
_____ Gingivitis or Periodontal disease
_____ Glaucoma
_____ Hay fever
_____ Headaches
_____ Heart Attack
_____ Heart Murmur
_____ Heart Surgery
_____ Hemophilia
_____ Hepatitis ___ Type
_____ Herpes/Fever Blister
_____ High Blood Pressure
_____ HIV + AIDS
_____ Jaw Pain/ TMJ
_____ Hospitalization for any reason
_____ Kidney problems
_____ Liver disease
_____ Low back/hip/leg pain
_____ Low blood pressure
_____ Lupus
_____ Mitral valve prolapse
_____ Neck/shoulder/arm pain
_____ Pace maker
_____ Psychiatric care
_____ Radiation Care
_____ Rashes
_____ Rheumatic/Scarlet fever
_____ Shingles
_____ Seizures
_____ Sexually transmitted disease
_____ Sickle cell disease
_____ Spasms/ Cramps
_____ Sprains/Broken Bones
_____ Tendonitis
_____ Thyroid Problems
_____ Tuberculosis (TB)
_____ Ulcers

Please list any significant medical condition(s) or surgeries that you have had (not listed above) ________________________
____
____
____

Allergies

Are you allergic to any of the following? Please answer with Yes or No

_____ Aspirin
_____ Codeine
_____ Dental Anesthetics
_____ Erythromycin
_____ Sulfites
_____ Latex
_____ Penicillin
_____ Tetracycline
_____ Any Metals
_____ Other

Please list any other drugs or items that you are allergic to:
____
____

Your Obligations

Cooperation
Successful dental treatment is a team effort involving you as the patient, the doctors and out team. Without cooperation, successful treatment planning, achieving optimal results and maintaining the treatment results are difficult or impossible and the results may be disappointing to everyone.

Scheduled Appointments
In order to serve our patients better, we strive to operate a professional, efficient dental practice. We attempt to reserve appropriate blocks of time for each of our patients so that the procedures may be completed with close attention to detail and with as few interruptions as possible. Missed appointments have a negative effect on our ability to maintain the level of service you and other patients deserve. While we are aware that circumstances may arise which interfere with set appointments, we require at least one business day notice for an appointment. Failure to provide this notice may result in a missed appointment fee which is, not intended as a penalty, but as a reasonable estimate of the time and expense incurred by the Practice in attempting to fill such a cancellation or loss of deposit.

Financial Obligation
You have full responsibility for payment of the dental services that you or your dependents receive here. Please understand that payment of your bill is considered part of your treatment.

- Full payment is due at the time of service.
- We offer extended payment plan with Care Credit

We do not require all co-payments to be made at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill insurance unless you bring in all insurance information and a completed original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. The estimate provided by this office is considered as a guideline until the final payment is received and the patient’s account has been reconciled. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered, and if not paid by the patient’s insurance company by the 61st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

Initials ___________

Medical History

Providing Timely Information & Authorization for Signature on File
To process insurance documents claims and related matters, you authorized the Practice to affix your signature and name to claims or documents related to insurance, claims or health benefits due to you. A photocopy of this form will act as an original. The Practice may disclose information provided by me or obtained during the course of my treatment, payment, or healthcare operations, including disclosure to laboratories, other dental offices or professionals involved in my care, and to my insurance providers. As part of your treatment, you authorize the Practice to take radiographs (x-rays), study models, provide injections, take photographs, and give and perform any other diagnostic tests and aids deemed appropriate by the Practice to evaluate your condition and to generate my recommendations, for professional or educational purposes and for any other use as contemplated or set forth in the Practice's current Notice of Privacy Policies.

Maintenance Obligation
For success treatment results and to lessen the risks of complication, you agree to comply with your individualized maintenance program and keep excellent home oral hygiene. It is typical to need follow-up visits for occlusal or other adjustments after treatment. You agree to notify the Practice at the soonest possible moment in the event that you experience pain, discomfort or any other problem that you believe may be related to treatment in our office. Nothing in this form extends to applicable statutes of repose or limitations for dental services. You agree to keep your follow-up appointments and to follow recommended treatments as well as follow other precautions and recommendations that may be provided as part of your pre-op or post- operative instructions.

Notice of Privacy Practices (HIPPA)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individual identification health information of which we have knowledge must be kept confidential. All personal health information used by or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of your legal duties and privacy practices health information.

We may be assessed a penalty for any misuse of unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on April 13, 2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provisions coordination, or management of health care and related services by one more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one provider to another. An example of this would be dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determination of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Healthcare operations are any activities related to covered functions in which we participate in the function of our offices, such conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administration activities, including implementation of this regulation; customer service evaluation; resolutions of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use to disclose your personal health information to carry out treatment, payment, or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all identifiable health information.

All other uses and disclosures will be made upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions taken, relying on your authorization, and prior to revocation notice.

Initials ____________

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact your for fundraising purposes.

Under HIPAA, you have the following rights with respect to your health information:

- You have the right to request restrictions on certain uses and disclosure of protected health information, including restrictions placed upon disclosure of family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restrictions;
- You have the right to receive confidential communications of your protected health information;
- You have the right to amend protected health information, however, this may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information, either by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice or privacy policies have been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health and Human Services, office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

I understand that I have certain rights to privacy regarding my protected health information. These are given to me under the Health Insurance Portability and Accountability Act of 1995 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name ____

Signature ____________________________ Date _________

Your Consent

The information I have provided on this form is accurate and complete to the best of my knowledge, information, and belief. I will notify the Practice at the soonest practical moment of any changes in the information I have provided. In consideration of being accepted as a patient of the Practice, I agree to abide by the terms and conditions of this Patient Application & Practice Agreement.

By signing below, I acknowledge that I have been given time to read and have completely read (or had read to me) the preceding information in this document and I acknowledge that the Practice has explained to me in general terms the descriptions of certain anticipated dental procedures and treatments, alternatives (including non-treatment) and the risks and inconveniences of treatments. By proceeding with each and every step in my treatment, I acknowledge that: (1) I have been given the opportunity to ask any questions and any questions have been answered or explained to my satisfaction prior to performance of any treatment or procedure, and (2) I authorize the Practice to perform any and all such recommended forms of treatment, medication and therapy that may be necessary or advised. I understand that during the course of the procedures described above, it may be necessary, appropriate, or the Practice's recommended to perform additional procedures which are unforeseen or not known to be necessary, appropriate, or recommended at the time this consent is given. I consent to and authorize the performance of such additional procedures as they deem necessary, appropriate, or recommended under the circumstances.

Signature ____________________________ Date ________

Patient's Authorized Representative
(If patient is under 18 years of age or you are consenting to the care of another)
I have the legal authority to sign this consent on behalf of:

Patient Name ____________________________________

Your relationship to Patient ___________________________

Signature ______________________________ Date________

For more information about HIPAA
Or to file a complaint, contact:

The U.S. Department of Health & Human Services
Offices of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
Toll Free (877)696-6775