BALLSTON DENTAL ARTS
DR. DUKE KIM, DDS, MAGD
900 N. TAYLOR ST. STE. 150 ARLINGTON, VA 22203 703- 931- 5555

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI

Gender: _____ Family Status: ◯ Single ◯ Married ◯ Other ◯ Child

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Ext:

Cell/Other # : _____ Email: _____

Address: _____
Street

_____
City State Zip Code

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

Address: _____, _____
Street City, State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____
Alerts:

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement Date:_____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____ Nursing _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other Drug Allergies
☐
☐ _____

Medications:

_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you see a Dr. now for any reason? ☐ Yes ☐ No
  Please explain_____ Name of Dr._____
- Do you have any other health problems that need clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Who may we thank for introducing you to us? _____

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INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First Mi

Insured's Birth Date: _____ Insured's SSN _____

Insured's Employer Name: _____

Address: _____, _____
Street City State Zip Code

Insurance Plan Name and Address: _____

CONSENT FOR SERVICES

I, the undersigned, authorize Dr. Duke H. Kim DDS, MAGD to take x-rays, study models, photos or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of the above patient's dental needs and authorize him to perform any and all forms of treatment, medication and therapy indicated for my optimum dental health.

I understand that payment of my bill is my legal obligation. In case that my account should become delinquent and is placed in the hands of an attorney for collection, I agree to pay attorney fees of 33 1/3% of the unpaid balance and interest owing plus all court costs and interest at a rate of 1.5% per month or 18% APR beginning 30 days after balance has become payable. I agree to pay a returned check charge of $25.00. I also understand and agree that I am responsible for services rendered to my spouse or children.

Dental Benefit Explanation

It is the policy of our practice to provide only the best dental services available to you. In order to do this it is important that we do not compromise that by allowing dental insurance companies to dictate the type of treatment you receive while in our care. Your treatment options are purely based on your dental needs and we assume that you are equally concerned about your dental health as well. We are pleased that you have dental benefits to assist you with the cost of your dental care and we are more than happy to assist you with getting the most out of your insurance plan.

Insurance Disclaimer

Please note that we do not participate with any insurance plans, prepay plans, Medicaid or discount plans. We are a fee for service practice. Our goal is to help you maximize your dental insurance benefits.

As a courtesy, we are happy to submit all the necessary paperwork to your dental insurance for your reimbursement of the services rendered. Payment by your insurance company may vary according to your individual plan when the actual claim is submitted. If you want to have a pretreatment estimate sent to your insurance company, you must specify this request to the office before any work is initiated. This process may take 6-8 weeks.

Regardless of coverage, your payment is due in full the day of treatment. If your insurance plan sends payment to the office, you will receive a refund check from us. Also, please remember that dental insurance plans are not designed to cover all of your dental needs, and that your dental benefits are between you, your employer and your insurance company.

For processing claim forms to the insurance company:

Assignment of Benefits: I authorize payment of benefits to the named provider for professional services rendered.

Release of Information: I authorize the release of any dental information necessary to process my dental insurance claims.

I AGREE TO PROVIDE NO LESS THAN 2 BUSINESS DAYS OR 48 HOURS ADVANCE NOTICE SHOULD I NEED TO RESCHEDULE AN APPOINTMENT RESERVED IN MY HONOR.

I UNDERSTAND A CANCELLATION FEE MAY APPLY WITHOUT PROPER NOTICE.

I HAVE READ THE ABOVE CONSENT TO TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*****

I, , have received a copy of this office's Notice of Privacy Practices.

_____
{Printed Name}

_____
(Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:

Address:

Telephone: (Home) **(Work):**

Email: **Social Security #**:

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, pay activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

SECTION C: TO THE PATIENT –RELEASE OF INFORMATION TO A THIRD PARTY

I give permission for you to release my personal health/financial information to the following individual in order to carry out treatment, payment activities, and healthcare operations.

Name: _____

Relationship: _____

Signature: _____ Date: _____

☐ I decline release of my information

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____