Karen Hom DDS
Family & Cosmetic Dentist
702•22•SMILE

Welcome

_____
today's date

about you

Patient Name _____

What You Prefer to be Called _____

Referred by _____

Birthdate ___/___/___ Age _____ SSN _____

mailing address:

_____
Street Address

_____
City State Zip

_____
Home Phone Work Phone

_____
Cell Phone Number

_____
Employer How Long

employer's address:

_____
Street Address

_____
City State Zip

Occupation _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____

Birthdate ___/___/___ Age _____ SSN _____

Person Responsible for Payment on Account

Name _____

Relation to Patient _____

billing address:

_____
Street Address

_____
City State Zip

SSN _____

_____
Home Phone Work Phone

Payment Method:

☐ Cash ☐ Check ☐ Credit Card

insurance information

primary dental insurance

_____
Company Name

_____
Address

_____
City State Zip

Eligibility Phone No. _____

_____
Insured's Name Relation

_____
Insured's SSN Birthdate

Insured's Employer _____

secondary dental insurance

_____
Company Name

_____
Address

_____
City State Zip

Eligibility Phone No. _____

_____
Insured's Name Relation

_____
Insured's SSN Birthdate

Insured's Employer _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for my insurance company.

_____
Signature Date

(continued)

in event of emergency

Patient Name

Who should we contact in an emergency Relation

Home Phone Work Phone

Who is your primary medical physician?

Phone Number for Physician

I understand the information provided on these two pages and guarantee that this form was completed correctly to the best of my knowledge. I further understand that it is my sole responsibility to inform the office of Dr. Karen Hom of any changes to this information that I have provided.

Signature Date

INSURANCE CLAIMS:

I have reviewed the treatment plan with a representative of Dr. Karen Hom's office and I authorize the release of any claim-related information. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment directly to Dr. Karen Hom's office of the group insurance benefits otherwise payable to me.

Signature Date

Date	Dr.'s Initials	Comments

health history

Allergic to any medications? ☐Yes ☐No

If *yes*, specify which medications

Allergic to latex? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

Allergic to any anesthetics? ☐Yes ☐No

If *yes*, specify which anesthetics

Any previous operations or surgeries? ☐Yes ☐No

If *yes*, please list

Any implants, artificial joints, valves (pins, screws)? ☐Yes ☐No

If *yes*, please list

Are you taking any medications presently? ☐Yes ☐No

If *yes*, please list

Are you under a physician's care presently? ☐Yes ☐No

If *yes*, why? Blood Pressure

Do you smoke? ☐Yes ☐No

Are you taking osteoporosis drugs? ☐Yes ☐No

Do you have or have you ever had any of the following:

☐Heart Problems
☐Mitral Valve Prolapse
☐Heart Murmur
☐Congenital Heart Disease
☐Pacemaker
☐High Blood Pressure
☐Low Blood Pressure
☐Stroke
☐Diabetes
☐Rheumatic Fever
☐Scarlet Fever
☐Typhoid Fever
☐Tuberculosis
☐Mumps
☐Arthritis
☐Circulatory Problems
☐Nervous Problems
☐Psychiatric Care
☐Excessive Bleeding
☐Allergies
☐Asthma
☐Sinus Problems
☐Anemia
☐Seizures
☐Hepatitis
☐Herpes
☐Veneral Disease
☐HIV Positive
☐AIDS
☐Malignancies
☐Ulcer
☐Radiation Treatment

Karen Hom
DDS
Family & Cosmetic Dentist
702•22•SMILE

Appointments not cancelled at least 24 hours in advance of appointment date and time will result in a $50.00 fee.

Signature Date

We will gladly accept your check as payment for services rendered. However, any checks returned due to insufficient funds will result in a minimum fee of $50.00.

Signature Date

7425 W. Azure Drive, Suite 110
Las Vegas, NV 89130
702.227.6453 • fax 702.733.7466

Karen Hom DDS
Family & Cosmetic Dentist
702•22•SMILE

NON-INSURED PATIENTS:

If you do not have insurance, our office policy requires 100% of the total fee due and payable at the end of your appointment today or at the time service is rendered.

INSURED PATIENTS:

Insurance is a vehicle that assists you, the patient, in covering the costs of the dental care which is provided to you. It is a contract between you and the insurance company. As a courtesy to our patients who do have dental coverage, we gladly accept your insurance as a partial payment and are happy to assist you in the processing of these claims.

Unfortunately, there is no contractual agreement between this dental office and your insurance carrier. ***Therefore, in the event that your insurance carrier does not pay within sixty (60) days of billing, the responsibility of payment of all fees incurred at the dental office of Karen Hom, DDS, reverts back to you. Should payment exceed sixty (60) days, a finance charge will be incurred.***

Our office policy requires that the patient pays their percentage of the total bill at the time service is rendered; this percentage depends on your carrier.

I/We hereby agree to be responsible for any cost of collection that the dental office of Karen Hom, DDS, may incur as a result of my/our account going to collections.

_____ _____

Signature of Patient or Guarantor Date

7425 W. Azure Drive, Suite 110
Las Vegas, NV 89130
702.227.6453 • fax 702.733.7466

Karen Hom DDS
Family & Cosmetic Dentist
702•22•SMILE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

you are entitled to a copy of this consent after signing it

Section A: PATIENT GIVING CONSENT

Name _____

Address _____

Telephone _____

Social Security Number _____

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, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this Consent. Our Notice provides a description of your treatment, payment activities, and health care 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 your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Karen Hom, DDS
702.227.6453 • fax 702.733.7466
7425 W. Azure Drive, Suite 110 • Las Vegas, NV 89130

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. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation and that we may decline to treat you or 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 the Consent form, I am giving you 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, please complete the following:

_____ _____
Name of Personal Representative Relation to Patient

Karen Hom DDS
Family & Cosmetic Dentist
702•22•SMILE

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 is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 5, 2003, and it 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may disclose your health information to obtain payment for the services provided to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include staff members, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations, 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 disclosure 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.

To Your Family and Friends: 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 a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, 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 or your location, your general condition, or death. If you are present, prior to the 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 incapacity or 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 health care. 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorizaiton.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health informaiton to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

7425 W. Azure Drive, Suite 110
Las Vegas, NV 89130
702.227.6453 • fax 702.733.7466

Karen Hom DDS
Family & Cosmetic Dentist
702•22•SMILE

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.

Name _____
please print

Signature _____

Date _____

FOR OFFICE USE ONLY

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

_____ The individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other: (be specific)

_____

_____

_____

_____

7425 W. Azure Drive, Suite 110
Las Vegas, NV 89130
702.227.6453 • fax 702.733.7466