Charles Kim, DDS
Young Kim, DDS

New Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Gender: ____ Age: _____

Preferred name: _____ Date of birth: _____

Home address: _____
Street City State Zip

Billing address: _____
(if different) Street City State Zip

Home phone: _____ Cell: _____

E-mail: _____

SS #: _____ Employer/Occupation: _____

Spouse's name: _____ Phone Number: _____

Who may we thank for referring you? _____

Insurance Information

Primary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

Secondary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

ACKNOWLEDGEMENT

OF

PRIVATE PRACTICES

Charles Kim, DDS
Young Kim, DDS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this Information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly\
- Obtain payment form a third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and Improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person indicated below, if necessary:

Any member of my immediate family	___ Yes	___ No
Spouse Only	___ Yes	___ No
Others (please specify)	___ Yes	___ No

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

◊ The patient refused to sign
◊ Communication barriers
◊ Emergency situation
◊ Other

Financial/ Cancellation Agreement

Thank you for choosing Gentle Smile Dental as your new dental home.

Please take a moment to read the following, and sign and date the bottom of this form.

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 60 days may be billed to you. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment without 24 hour notice will result in a $50 charge for the time reserved, as this time could be given to another patient in need.

There will be a minimum fee of $50 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 120 or more days may be referred to a collection company or attorney.

I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

SIGNATURE_____ DATE:_____