Patient Information Michael Hyodo & Johann Yi DDS

TODAY'S DATE	ACCT.#					
PATIENT NAME	NICK NAME					
HOME PHONE			EMAIL			
			ZIP			
DATE OF BIRTHAG	ESEX	M F	S/S#			
CIRCLE ONE SINGLE	MARRIED	DIVORCED	WIDOWED CHILD			
IS THERE AN EXISTING FAMILY ACC	COUNT IN THIS OFF	ICE?	YES NO			
IF YES NAME(S) OF THE FAMILY ME	MBER(S)					
WHO MAY WE THANK FOR REFERR	RING YOU TO US?					
CLOSEST RELATIVE/FRIEND NOT LI	VING AT YOUR RES	SIDENCE?(FOR E	MERGENCY)			
NAME		PHONE#				
PATIENT EMPLOYER		OCCUPATION				
SPOUSE'S NAME		EMPLOYED BY				
OCCUPATION		WORK PHONE				
SPOUSE'S SS#	SPOUSE'S BIRTHDATE					
INSURANCE INFORMATIO	N					
PRIMARY DENTAL INSURANCE_			PHONE#			
INSURANCE ADDRESS						
SUBSCRIBER NAME(EMPLOYEE)			GROUP#			
		SS#				
			PHONE#			
INSURANCE ADDRESS						
SUBSCRIBER NAME(EMPLOYEE)		GROUP#				
DATE OF BIRTH			SS#			
As a courtesy, we will process your	insurance provided	that all the informat	tion is accurate and complete.			
FOR MINORS						
FATHER'S NAME		EMPLO	OYED BY			
EMPLOYER ADDRESS & PHONE						
			DATE OF BIRTH			
			OYED BY			
EMPLOYER ADDRESS & PHONE						
OCCUPATION	SS#		DATE OF BIRTH			

MEDICAL HEALTH HISTORY BELLEVUE DENTAL CARE

0 111 111 /01 01 1				
General Health(Please Circle (One) Excellent	Good Fair F	Poor	
Physician's Name			Phone	
Last complete physical	Are you taking any	medications now?	Yes No If yes, what kind?	
Have you over been to	reated for or been asso	ociated with/places	irala)	
nave you ever been u	reated for or been asso	ociated with(piease c	ircle)	
Heart Disease	Rheumatic Fever	Diabetes	Implants	
Ulcer	TB/Lung Disease	Hernia	Radiation Therapy	
Anemia	Herpes	Hepatitis	Jaundice	
Cancer	Heart Murmur	Arthritis	Asthma/Hay Fever	
Stroke	Sinus Trouble	Epilepsy	Venereal Disease	
Glaucoma	Pacemaker	High/Low Blood F	Pressure	
AIDS/HIV Antibody	Subject to F	Prolonged Bleeding	Other:	
			No	
Name of Previous Dentist		Phon	e	
Date of Last Dental Care				
Do you have any dental conce				
Please print patient's name		 Patient/Guard	ian Signature	
r rougo primi punom o mumo	/ 6		o.g	
Date N	oft) Medical Changes and/	fice use) or Medications since	e last visit Initia	als
Do you have any other health If yes please explain: If you could change the appea	nt? Yes No conditions that are not are	If yes, how far t listed? Yes hat would it be? Phon	along? No	

STATEMENT OF PRIVACY PRACTICES

Bellevue Dental Care

www.bellevuedentalcare.net 1515 116th Avenue Northeast #206, Bellevue, WA 98004 425-454-1225

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

• Protecting you personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone-even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

• Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcard.

• Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for you copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal healthy information.