

Patient Information

Name _____
Last

_____ First Middle

Address _____

City State Zip

Phone (Home) _____ (Cell) _____

E-mail _____

Birthdate _____

SS# _____

Sex M F

Single Married Widowed Divorced Minor

Separated Partnered for _____ years

Employer/School _____

Occupation _____

Spouse's Name _____

Spouse's Birthdate _____

Spouse's SS# _____

How did you hear about us?

Referred by patient (name) _____

Website _____ Other _____

Insurance Information

Primary Plan Member Information:

Name of Insured _____

Relationship to Patient _____

Insured's Date of Birth _____
Month/Day/Year

Insured's SS# _____

Insurance Co. Name _____

Member ID# _____

Is patient covered by additional insurance? Y N

Name of Insured _____

Relationship to Patient _____

Insured's Date of Birth _____
Month/Day/Year

Insured's SS# _____

Insurance Co. Name _____

Member ID# _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to James B. Lee, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

X _____
Responsible Party Signature

Relationship to Patient Date

Office Policies

Please place your initials by each to indicate that you have read and agreed to our policy.

_____ At least 24 hours advance notice is required for all appointment changes or cancellations. Otherwise, a \$50 fee is charged for each appointment so affected.

_____ If you have questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations.

_____ Please be advised that the co-payment requested for services rendered is only an estimate of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is **not a guarantee of payment**, and the actual insurance benefit may differ from our estimates. **The account holder is responsible for all charges the insurance company does not pay.**

_____ Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

X _____
Responsible Party Signature

Date

Health History Form

As required by law our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name _____ Date of Birth _____

Home () _____ Cell Phone () _____ May we use this number to send text notifications regarding your appointments? YES / NO

Address _____
City State Zip

SSN _____ Emergency Contact _____
Name Ph. # Relationship

Do you have any of the following diseases or problems? (Mark DK if you don't know the answer to the question)	Yes	No	DK
Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3-week duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information (Mark DK if you don't know the answer to the question)

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitivity to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear partials or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in recreational activities/sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink bottled/filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam and/or x-rays? _____			

Medical Information

Are you now under the care of a physician? Yes / No Physician/Facility Name _____ Ph. # _____

Have you had a serious illness, operation or hospitalization within the past 5 years? Yes / No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes / No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

(Continued on other side)

Medical Information (Please indicate if you have or have not had any of the following. Mark DK if you don't know) Yes No DK

Joint Replacement - Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had complications? (specify) _____

Are you taking or will you begin taking either: alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Do you use controlled substances (drugs)?

Do you use tobacco (smoking, snuff, chew, beedis)?

If so, how interested are you in quitting? (Please circle) **VERY / SOMEWHAT / NOT INTERESTED**

Do you use e-cigarettes / vape pens?

Do you drink alcoholic beverages?

If yes, how much do you typically drink in a week? _____

If yes, have you had any drinks in the last 24 hours? What amount? _____

WOMEN ONLY - Are you: Yes No DK
 Pregnant?
 If yes, number of weeks: _____
 Taking birth control pills or hormonal replacement?
 Nursing?

Allergies - Are you allergic to or have you had an allergic reaction to any of the following (Please circle if yes & specify type of reaction):
 Local anesthetics _____ Metals _____ Food _____
 Codeine/Other narcotics _____ Latex (rubber) _____ Iodine _____
 Hay fever/Seasonal _____ Animals _____ Aspirin _____
 Penicillin/Other antibiotics _____ Sulfa drugs _____
 Barbiturates, sedatives or sleeping pills _____ Other _____

Illness / Disease / Condition (Please indicate if you have or have not had any of the following. Mark DK if you don't know) Yes No DK

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged vales in transplanted heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion (when? _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/chemotherapy/radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorder (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment?
 Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition or problem not listed above that you think I should know about?
 If yes, please explain: _____

NOTE: Both Doctor & patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read & understand the above and that the information given on this form is accurate, I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any members of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

James B. Lee, DDS

Financial Policy Agreement

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with services, treatments, procedures and/or diagnostic methods performed and utilized by Dr. James B. Lee and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. Dr. James B. Lee is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to Dr. James B. Lee for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office of Dr. James B. Lee will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it). I acknowledge that it is my responsibility to provide the dental office of Dr. James B. Lee with my current insurance or managed care information and any changes thereto.

Any account balances that remain unpaid for 180 days from the date of service may be referred to a collection company. In the event this occurs, I acknowledge and understand that I am responsible for all costs incurred in connection therewith.

I consent to be contacted by Dr. James B. Lee, any agent of the dental office of Dr. James B. Lee, or any collection agency to whom an unpaid account balance has been assigned or referred by mail and/or at any facsimile number, email address or phone number (whether cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Name: _____

Date: _____

Patient Signature: _____

Guardian/Responsible Party (if minor): _____

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 READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 10/01/2022, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for your treatment, payment, and healthcare operations. For example:

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

Billing & Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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 healthcare operation, 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 disclosures 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 describes 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 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, of your location, your general condition, or death. If you are present, then prior to 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 determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your healthcare. 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.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

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

National Security: We may disclose to military authorities the health information of Armed Forces personal under certain circumstances. We may disclose to authorized federal officials health information required to lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format that you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide a satisfactory explanation how payments will be handled under the alternative means or location that you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by e-mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: James B. Lee, D.D.S.

Telephone: (562) 867-1753

Fax: (562) 867-2091

E-mail:

jamesleedds@lakewooddental.com

Address: 5828 Adenmoor Avenue
Lakewood, CA 90713

James B. Lee, D.D.S.

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 (Printed): _____

Date: _____

Name (Signed): _____

----- 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

If other please specify: _____

