DENTAL ONCOLOGY
PROFESSIONALS

Soomin Richard Kim, D.D.S., M.P.H.
6452 Broadway Blvd.
Garland, TX 75043
Phone: 972.226.6947 Fax: 972.226.6608

Name of Patient_____Date_____

Address_____Apt._____City_____

State _____ Zip _____ Home Phone_____ Cell Phone_____

If minor, Name of Guardian _____ Guardian's Phone _____

Employer _____ Occupation _____

Business Address_____

Business Phone _____ Email_____

Patient's SS# _____ DL#_____

DOB _____ Married/Single/Partner Gender _____

Spouse's Name_____ Spouse's Cell Phone _____

Spouse's Employer _____ Spouse's Occupation _____

Responsible Party (if not patient) _____

Emergency Contact _____ Cell Phone _____

Names of other family members who are patients _____

How did you find out about our office?_____

Dental Insurance

PRIMARY	Secondary
Insurance Company_____	Insurance Company_____
Name of Insured_____	Name of Insured_____
ID/SS#_____	ID/SS#_____
Insurance Phone #_____	Insurance Phone #_____
Employer _____	Employer _____
Group # _____	Group# _____

Important Notice: Please be aware that insurance verification tells us only that you have a policy in force. It DOES NOT tell us how much the insurance will pay for certain procedures. Predetermination of benefits is likewise not a guarantee of payment. The payable benefits can only be determined after your insurance company has received and processed your claim. Accordingly, regardless of the amount collected at the time of service, you are responsible for the full amount of charges relating to all services rendered. If you have any questions regarding the coverage of our services, you must contact your insurance carrier. Your insurance coverage is a contract between you and your carrier. Only they can control the amounts paid on your behalf.

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PERSONAL HEALTH HISTORY

as of _____
(today's date)

Patient name: _____ Date of birth: _____

Please answer the following questions to the best of your ability by checking the box that is appropriate for you. Knowing this information is critical in providing you the very best personal care you deserve. Please answer each question thoughtfully, and do not hesitate to ask a team member to clarify any item you do not understand. Thank you for your co-operation.

MEDICAL HISTORY

	Yes	No	Don't Know
Have there been any major changes in your health within the past year?			
If yes, please explain:			
Are you under the care of a physician or currently receiving medical care?			
Name of physician: *Physician's phone:*			
Do you have any artificial joints, heart valves, or limb protheses?			
Have you been diagnosed with mitral valve prolapse with regurgitation?			
Do you have a pacemaker?			
Are you the recipient of a solid tissue organ transplant (*e.g.* lung, heart, kidney, *etc.*)?			
If yes, which organ? *When?*			
Have you ever received a bone marrow or hemopoietic stem cell transplant?			
If yes, when?			
Have you ever been told you need to be premedicated prior to dental treatment?			
Do you currently have a port, mediport, or other venous catheter?			
Have you ever received or are you currently receiving bisphosphonate therapy?			
If yes, please circle.: Zometa Denosumab Xgeva Prolia Reclast Aredia Fosamax Boniva Other			
For women only: Are you pregnant? *If yes, due date:*			
For women only: Are you currently breastfeeding?			

6452 BROADWAY BOULEVARD GARLAND, TEXAS 75043
TEL 972.226.6947 FAX 972.226.6608 WEB www.dentaloncology.com

Patient name: _____ Today's date: _____

ONCOLOGY:

	Yes	No	Don't Know
Have you ever been diagnosed with some type of cancer?			
If yes, please complete this section. If no, please proceed to MEDICATIONS section.			
Type of cancer: Stage, if known:			
Will/Did your cancer treatment include surgery?			
Will/Did your cancer treatment include radiation therapy?			
If yes, dates of treatment:			
Will/Did your cancer treatment include chemotherapy?			
If yes, dates of treatment: *Type of chemo, if known:*			
Will/Did your cancer treatment include immunotherapy or biological therapy?			
If yes, dates of treatment: *Type, if known:*			
Do you currently have a PEG/feeding tube?			

Comments: _____

_____

MEDICATIONS:

	Yes	No	Don't Know
Are you taking any prescription, over-the-counter medication, or supplement?			

Please list all medications you are taking. Include prescriptions, over-the-counter medications, and vitamin/mineral/nutraceuticals. If necessary, please check box and continue on back of page. ☐

MEDICATION **DOSAGE** **FREQUENCY**

_____

_____

_____

_____

_____

ALLERGIES:

	Yes	No	Don't Know
Are you allergic to any medication?			
Do you have any other allergies?			

Please list all allergies and explain reaction. If necessary, please check box and continue on back. ☐

ALLERGY **REACTION**

_____

_____

_____

Patient name: _____ Today's date: _____

SOCIAL:

	Yes	No	Don't Know
Do you use tobacco?			
If yes, what kind? *How much?*			
Do you drink alcohol?			
If yes, how many drinks per week? (One drink = 1 oz. liquor/5 oz. wine/12 oz. beer)			
Have you used any illegal drug within the past year?			
Have you ever found it difficult to quit taking a prescription medication?			

Comments: _____

_____

Do you currently have -OR- have you ever had any of the following diseases, conditions, or issues?

LUNG/BREATHING ISSUES (RESPIRATORY SYSTEM):

	Yes	No	Don't Know
Hay fever			
Shortness of breath			
Persistent cough			
Positive test/treatment for tuberculosis (TB)			
Seasonal allergies			
Asthma			
Emphysema			
Chronic obstructive pulmonary disease (COPD)			
Coughing up blood			
Other respiratory/breathing/lung issues			

Comments: _____

_____

HORMONE/GLAND ISSUES (ENDOCRINE SYSTEM):

	Yes	No	Don't Know
Diabetes *(If yes, circle appropriate.)* Type 1 Type 2			
If yes, is diabetes well-controlled? *Recent A1C:* *Recent blood glucose:*			
Thyroid problems			
Other hormone/gland/endocrine issues			

Comments: _____

Patient name: _____ Today's date: _____

HEART/VASCULAR ISSUES (CIRCULATORY SYSTEM):

	Yes	No	Don't Know
Heart attack			
If yes, when?			
High blood pressure			
If yes, is condition controlled?			
Chest pain (Angina)			
Heart murmur			
Atherosclerosis / Coronary Artery Disease			
Bypass surgery/stent placement			
If yes, when?			
Other heart/circulatory/vascular issues			

Comments: _____

BLOOD ABNORMALITIES:

	Yes	No	Don't Know
Bleeding problems			
Anemia			
Hemophilia			
Blood clots / Deep vein thrombosis (DVT)			
Are you taking blood thinners?			
If yes, what is your recent PT/INR result, if known.			
Other blood/bleeding issues			

Comments: _____

LIVER ISSUES (HEPATIC SYSTEM):

	Yes	No	Don't Know
Hepatitis *(If yes, circle appropriate.)* Type A Type B Type C *When?*			
Alcoholic liver disease			
Other liver/hepatic issues			

Comments: _____

Patient name: _____ Today's date: _____

KIDNEY ISSUES (RENAL SYSTEM):

		Yes	No	Don't Know
Kidney disease	*If yes, which stage?*			
Currently on dialysis	*If yes, on which days?:*			
Other kidney/renal issues				

Comments: _____

STOMACH/DIGESTIVE ISSUES (GASTROINTESTINAL SYSTEM):

		Yes	No	Don't Know
Stomach pain				
Frequent heartburn				
History of ulcers				
Colitis, Irritable Bowel Syndrome (IBS), or Crohn's disease	*Please circle, if applicable.*			
Frequent vomitting				
Other stomach/digestive issues				

Comments: _____

_____

MUSCLE/BONE/JOINT ISSUES (MUSCULOSKELETAL SYSTEM):

		Yes	No	Don't Know
Joint/back pain				
Joint swelling				
Rheumatoid arthritis	*If yes, location:*			
Osteoarthritis	*If yes, location:*			
Temporomandibular joint dysfunction				
Other muscle/bone/joint issues				

Comments: _____

_____

NEUROLOGIC ISSUES (CENTRAL NERVOUS SYSTEM):

	Yes	No	Don't Know
Epilepsy / Seizure disorder			
Chronic headaches			
History of head injury			
Numbness of arms, legs, hands, or feet			
Fainting spells / syncope			

Patient name: _____ Today's date: _____

NEUROLOGIC ISSUES (CENTRAL NERVOUS SYSTEM) cont'd:

	Yes	No	Don't Know
History of stroke			
If yes, please explain:			

Comments: _____

GENITOURINARY ISSUES (GENITOURINARY SYSTEM):

	Yes	No	Don't Know
Frequent urinary tract infections (UTI)			
Venereal disease			
If yes, please explain:			
For women only: Vaginal yeast infection with antibiotics use			
For women only: Post-menopausal			
For men only: Erectile dysfunction (ED shown to be associated with oral bacteria.)			

Comments: _____

IMMUNE/AUTOIMMUNE ISSUES (IMMUNE SYSTEM):

	Yes	No	Don't Know
HIV / AIDS			
Immune system disorders			
Sjögren's syndrome			
Psoriasis / Eczema / Rosacea *Please circle appropriate.*			
Other autoimmune issues			
If yes, please explain in detail.:			

Comments: _____

MENTAL HEALTH:

	Yes	No	Don't Know
Depression			
Anxiety			
Other mental health issues/disorders			

Comments: _____

OTHER:

	Yes	No	Don't Know
Do you have any other disease, condition, or issue not listed or reported thus far?			
If yes, please explain in detail.:			

Comments: _____

Patient name: _____ Today's date: _____

DENTAL AND ORAL HEALTH HISTORY

	Yes	No	Don't Know
Are you having any dental discomfort at this time?			
If yes, please explain:			
Have you ever had serious trouble with previous dental work?			
If yes, please explain:			
Does having dental work make you nervous?			
If yes, please mark on scale: Slightly nervous ——— Extremely nervous			
Have you ever experienced any abnormal bleeding after a dental procedure?			
If yes, please explain:			
Have you previously been diagnosed with gum disease?			
Date of your last dental visit:			
Date of your last dental cleaning:			
Name of previous dentist: Location:			
How often do you brush your teeth?			
How often do you floss your teeth?			
Have you ever had braces?			
Have you ever had gum surgery?			
Do you feel like your mouth is dry?			
Do you wear a denture or partial denture?			
If yes, does it fit well?			
Are you happy with the appearance of your teeth?			
If no, what would you change?			

Comments: _____

_____

I understand that, to the best of my knowledge, all of the preceding answers are true and correct. I understand if I ever have any changes in my health or in the medications I am taking, I must inform your office immediately. I hereby give my consent of treatment for myself or the named patient (of whom I am the parent, legal guardian, or foster parent) to Dr. Dennis Abbott and Dental Oncology Professionals.

Signature of Patient or Guardian: _____ Date: _____

Signature of Dentist / Hygienist: _____ Date: _____

Dental Oncology Professionals
Dr. Kim and Staff

Informed Consent

The undersigned hereby authorizes Doctor or his staff to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I authorize Doctor to perform treatment that may be indicated, understanding that it is my right to approve or deny said diagnosed treatment after discussion of the risks and benefits involved. I also understand the use of anesthetic agents embodies a certain risk. I understand that I am responsible for payment for dental services, and that this payment is due at time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 90 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of the note.

I authorize the use of all images for educational and professional purposes.

I further authorize the release of information to the Insurance carrier(s) and authorize payment directly to the Doctor.

I am aware a 24 hour notice is required to cancel appointments. If the courtesy of one full BUSINESS day is not given to change an existing appointment, the office reserves the right to assess a cancellation charge of $50.00 per hour, that was scheduled.

Patient Signature: _____Date:_____

Guardian Signature (if patient is under age 18):_____

Dental Oncology Professionals
Dr. Kim and Staff

IMPORTANT NOTICE

Please note: Dr. Soomin Richard Kim is OUT-OF-NETWORK with ALL insurance companies.

When you make an appointment with our office, the insurance verification information that is available to us tells us ONLY that you have a policy in force. The verification process CANNOT tell us if your insurance will pay or how much it may pay for the service you have received. Predetermination of benefits is likewise NOT a guarantee of payment. The payable benefit can only be determined AFTER your insurance company has received and processed your claim.

Accordingly, REGARDLESS of the amount collected at the time of the appointment, you are responsible for the FULL amount of charges relating to all services rendered.

If you have ANY questions regarding to the coverage of our services, you must contact your insurance company. Your insurance coverage is a contract between you and your carrier. Only they can control the amounts paid on your behalf.

Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to Dr. Soomin Richard Kim all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services.

I certify that I am responsible for services not paid by my insurance company and also will pay any late fees, collection cost or legal fees on my account that is delinquent past 90 days.

Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Dental Oncology Professionals
Dr. Kim and Staff

ELECTRONIC INFORMATION UPDATE

Please print your name and email address on this form and sign the notice at the bottom of the page.

Name:_____

Email: _____

Alt. Email: _____

I understand that by providing my email address, electronic communication will be limited to correspondence from the office of Soomin Richard Kim, D.D.S., M.P.H. and falls within the guidelines of HIPAA. I further understand that under no circumstances will my private information, including my email address, be given to a third party without my written consent.

Signature_____ Date:_____

Dental Oncology Professionals
Dr. Kim and Staff

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY POLICY

"You may refuse to sign this acknowledgement"

I, _____have been informed of this office's Notice of Privacy Policies.

_____
Print 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 barriers prohibited obtaining the acknowledgement
*An emergency situation prevented us from obtaining acknowledgement
*Other (Please Specify)

_____

_____

_____

Soomin Richard Kim, DDS,
MPH
6452 Broadway Blvd
Garland
Texas, 75043

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Soomin Richard Kim, DDS, MPH 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 10/12/21, 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 treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 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 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 described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 a determination using our professional judgment disclosing only health information that is directly relevant to the person's 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.

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

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 reasonably 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 safety or the health or safety of others.

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

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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, postcards, text messages or 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 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. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format,

of this Notice for a full explanation of our fee structure.)

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. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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 additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location 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 Web site or by electronic mail (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 a decision we made about access to your health information or in response to a request you made to amend or restrict the use or 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 also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Norberto Diaz-Tracy Stewart
Telephone: 9722266945
E-mail: norberto@dopnt.com
Address: 6452 Broadway Blvd
Zip Code: 75043
State: Texas
City: Garland