Date__________________

7255 Joshua Lane, Suite B
Yucca Valley, CA, 92284

760.365.8331

Welcome to our office. Please print your responses to the following questions in order to assist us to help you. Your information is private and protected.

Name:___________________________________ Birth Date:______________________SSN:______________
Mailing Address:____
City:______________________________________State:__________________________Zip Code___________
Phone (cell):___________________________________(Home)____
Employer:____
Email Address:____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (If self write SELF)

Name:_______________________________________BirthDate:______________________SSN:______________
Mailing Address:____
City:______________________________________State:__________________________Zip Code:___________
Phone (cell):___________________________________(Home)____
Employer:____
Email Address:____

PRIMARY DENTAL INSURANCE

Ins Company:________________________________Ins Phone:____
Claims Mailing Address:________________________City:____________________State:_______ZIP:________
Policy Holder Name:______________________________BirthDate:__________________SSN______________
Employer:__________________________________Group No:___________________ID No:________________

SECONDARY DENTAL INSURANCE

Ins Company:________________________________Ins Phone:____
Claims Mailing Address:________________________City:____________________State:_______ZIP:________
Policy Holder Name:______________________________BirthDate:__________________SSN______________
Employer:__________________________________Group No:___________________ID No:________________

EMERGENCY CONTACT

Name:____Relation:____
Phone:____________________________________Alternate Phone:_____________________________________
Physician:_________________________________Phone:____

ALTERNATE CONTACT

Name:____Relation:____
Phone:____________________________________Alternate Phone:_____________________________________

PREFERRED PHARMACY

Name:_______________________________________ Location:____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

Name:____

Joshua Lane Dental
7255 Joshua Lane, Suite B
Yucca Valley, CA 92284
(760)365-8331

Name_________________

DENTAL INFORMATION

What is your main concern with your teeth?____

Please circle where applicable:

Bad breath or taste	Sensitive teeth	Clenching or grinding
Bleeding gums	Pain around ear	Frequent headaches
Difficulty chewing foods	Dry mouth	Other

Long term goals____

Any trouble with previous dental treatment?____

ORAL HYGIENE: What do you use?

Toothbrush	Floss	Interdental stimulators
Automatic Toothbrush	Toothpicks	Water jet device
Fluoride supplement or gel	Other	

FEAR: Please Indicate(0=none, 1=mild, 2=moderate, 3=severe, 4=disabling panic)

Calling for an appointment	Sitting in dental chair	Having an injection
Waiting in the reception room	Having teeth x-rayed	Having teeth drilled
Smell of a dentist office	Seeing dental instruments	Having an extraction
Seeing the dentist	Having teeth cleaned	Losing control

AUTHORIZATION

I authorize my dentist and his designated staff to perform an oral examination for the purpose of diagnosis and treatment planning including the taking of all x-rays as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment

FEE & PAYMENT

I understand an estimate of the charge for any procedure I may require will be provided to me. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents. I understand that dental insurance is a method of reimbursement for fees paid to the doctor, <u>and my insurance carrier may pay less than the actual bill for services.</u> In addition, I have been informed of the practices fail to show and/or cancellation fee without 48 hour prior notice.

SIGNATURE

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor of the benefits otherwise payable to me.

Signature:____ **Date:**___________________

Joshua Lane Dental 760.365.8331

7255 Joshua Lane, Suite B Date____________________

Yucca Valley, CA 92284 Name____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physicians' care now? Yes No If yes, please explain______________________________
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain______________________________
Have you ever had a serious head or neck injury? Yes No If yes, please explain______________________________
Are you taking any medications, pills or drugs? Yes No If yes, please explain______________________________
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain______________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, please explain______________________________
Are you on a special diet? Yes No

Do you use alcohol? Yes No Daily ☐ Weekly ☐
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women:
Pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No
Trying to get pregnant? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local anesthetics Acrylic Metal Latex Sulfa drugs
Other If yes, please explain:____

Do you have, or have you had, any of the following? Please indicate no, if N/A and circle yes if applicable.

AIDS/HIV Positive	**Yes No**	**Cortisone medication**	**Yes No**	**Hemophilia**	**Yes No**	**Radiation treatment**	**Yes No**
Alzheimer's Disease	**Yes No**	**Diabetes**	**Yes No**	**Hepatitis A**	**Yes No**	**Recent weight loss**	**Yes No**
Anaphylaxis	**Yes No**	**Drug addiction**	**Yes No**	**Hepatitis B or C**	**Yes No**	**Renal dialysis**	**Yes No**
Anemia	**Yes No**	**Easily winded**	**Yes No**	**Herpes**	**Yes No**	**Rheumatic fever**	**Yes No**
Angina	**Yes No**	**Emphysema**	**Yes No**	**High blood pressure**	**Yes No**	**Scarlet fever**	**Yes No**
Arthritis/Gout	**Yes No**	**Epilepsy or seizures**	**Yes No**	**High cholesterol**	**Yes No**	**Shingles**	**Yes No**
Artificial Heart Valve	**Yes No**	**Excessive bleeding**	**Yes No**	**Hives or rash**	**Yes No**	**Sickle cell disease**	**Yes No**
Artificial joint	**Yes No**	**Excessive Thirst**	**Yes No**	**Hypoglycemia**	**Yes No**	**Sinus trouble**	**Yes No**
Asthma	**Yes No**	**Fainting spells/Dizziness**	**Yes No**	**Irregular heartbeat**	**Yes No**	**Spina Bifida**	**Yes No**
Blood disease	**Yes No**	**Frequent cough**	**Yes No**	**Kidney problems**	**Yes No**	**Stomach/ intestine disease**	**Yes No**
Blood Transfusion	**Yes No**	**Frequent diarrhea**	**Yes No**	**Leukemia**	**Yes No**	**Stroke**	**Yes No**
Breathing problem	**Yes No**	**Frequent Headaches**	**Yes No**	**Liver disease**	**Yes No**	**Swelling limbs**	**Yes No**
Bruise easily	**Yes No**	**Genital herpes**	**Yes No**	**Low blood pressure**	**Yes No**	**Thyroid disease**	**Yes No**
Cancer	**Yes No**	**Glaucoma**	**Yes No**	**Lung disease**	**Yes No**	**Tonsillitis**	**Yes No**
Chemotherapy	**Yes No**	**Hay Fever**	**Yes No**	**Mitral valve prolapse**	**Yes No**	**Tuberculosis**	**Yes No**
Chest Pain	**Yes No**	**Heart attack/failure**	**Yes No**	**Osteoporosis**	**Yes No**	**Tumors or Growth**	**Yes No**
Cold sore/Fever Blister	**Yes No**	**Heart Murmur**	**Yes No**	**Pain in jaw joints**	**Yes No**	**Ulcers**	**Yes No**
Congenital heart disorder	**Yes No**	**Heart pacemaker**	**Yes No**	**Parathyroid disease**	**Yes No**	**Venereal disease**	**Yes No**
Convulsions	**Yes No**	**Heart trouble/disease**	**Yes No**	**Psychiatric care**	**Yes No**	**Yellow Jaundice**	**Yes No**

Have you ever had any serious illness not listed above? Yes No. If yes, what and when ______________________________

Medication:
Please list any medications you are currently taking:____
____

My signature certifies the information provided is true and complete to the best of my knowledge. I understand my health could be adversely affected if anything is omitted or incorrectly disclosed.

Signature:____

Joshua Lane Dental
7255 Joshua Lane, Suite B
Yucca Valley, CA 92284
760.365.8331

Date____________________
Name___________________

DENTAL TREATMENT CONSENT FORM

Patients Name:____
Please read and initial the items below and sign at the bottom of the form.

☐ 1. **X-rays (initials___________)**

☐ 2. **Drugs and Medications**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction) **(initials____________)**

☐ **3. Changes in the treatment plan**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.
(initials_____________)

☐ **4. Fillings**
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that was not initially diagnosed may be required due to any additional decay. I understand that significant sensitivity is common after a newly placed filling. **(initials_______________)**

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that there is no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient:____

Signature of Parent/Guardian (if minor)_______________________________

Joshua Lane Dental
7255 Joshua Lane, Suite B
Yucca Valley, CA 92284
760.365.8331

Date____________________

Name____________________

Notice of Privacy Practices & HIPAA Disclosure

Dear Valued Patient,

It's our desire to communicate to you that our office is enacting a serious federal law, HIPAA (Health Insurance Portability and Accountability Act). This law protects the confidentiality of your health information. This means, we will use it to communicate your health information for the purpose of providing your treatment, obtaining payment, conducting healthcare operations and otherwise described in this notice.

You will be asked by your dentist to sign a consent/acknowledgement form. By signing this form your dentist, our office staff and others outside the office, involved in your dental care and treatment, for the purpose of providing healthcare to you. Your Personal Health Information (PHI) may also be disclosed to pay your health insurance bills and support the operations of the dental office.

We have contracted with one or more third parties (referred to as business associate's) to use and perform services for our office, such as billing services. We have obtained each business associate's written agreement to safeguard your health information.

Federal law generally permits us to make certain uses or disclosures without your permission. Federal law requires our office to disclose these, and they are as follows:

- **Abuse and Neglect**
  We may disclose your PHI to the responsible government agency if the Privacy Office believes that you are a victim of abuse, neglect, or domestic violence. We are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Officer determines that informing you is against your best interest.
- **Public Health and National Security**
  We are required to disclose to Federal officials or military authorities the necessary PHI to complete an investigation related to public health or national security.
- **For Law Enforcement**
  As permitted or required by State or Federal Law, we may disclose your PHI for certain circumstances, such as if you were a victim of a crime.
- **Family and Caregivers**
  We may share your PHI with those who you disclose to us as helping with your dental treatment. In case of an emergency, where you are unable to tell us what you want, we will use our best judgment in sharing your information only when it will be important to those participating in providing your care.
- **Worker's Compensation purposes**
  We may disclose your PHI as required or permitted by state or federal worker's compensation laws
- **Judicial and Administrative**
  We may disclose your PHI in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will Disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.
- **Incidental Uses and Disclosures**
  We may use or disclose your PHI in a manner which is incidental to the uses and disclosures described in this notice
- **Health Oversight Activities**
  We may disclose your PHI to a government agency responsible for overseeing the health care system or health-related government programs
- **To Avert a Serious Threat to Health or Safety**
  We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or the public
- **To the U.S. Department of health and Human Services (HHS)**
  We may disclose your information to HH, the government agency responsible for regulating and enforcing HIPAA laws.

- **In Connection with Death and Organ Donation**
  We may disclose your PHI to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one or more of your organs.
  If applicable State laws do not permit the disclosure described above, we will comply with the stricter law.
- **Authorization to use or disclose PHI**
  We are required to obtain your written authorization in the following circumstances:
  A. To use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you)
  B. To use your PHI for marketing purposes
  C. To sell you PHI
  D. To use or disclose your PHI for any purpose not previously described in this Notice.
  We will also obtain your Authorization before using or disclosing your PHI when required to do so by:
  A. State laws, such as laws restricting the use or disclosure of genetic information or information concerning HIV status
  B. Other federal law, such as federal law protecting the confidentiality of substance abuse records

You may revoke any of these Authorizations in writing at any time.

- **Patient Rights**
  You have the following rights related to your PHI.
  1. **Restrictions**
     You have the right to request restrictions on the use or disclosures of your PHI for treatment, payment, or healthcare operations, in addition to the limitations of federal law. Our office is not required to agree to your request unless you request that we do not disclose your PHI to an insurance company for payment for healthcare operation purposes. Unless someone on your behalf has paid us in full for the healthcare item or service to which the PHI pertains. We are not required by law to disclose to the insurer the PHI is the subject of your request, but we will endeavor to honor reasonable requests. We are generally not required to agree to such a request. Our officer will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.
  2. **Confidential Communications**
     You have the right to request that we communicate with you by alternative means or to an alternative location. You may, for example, request that we may communicate you PHI only privately, with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.
  3. **Inspect and Copy your PHI**
     You have the right to read, review, and copy your PHI. Including your complete chart, x-rays, and billing records. If you would like a copy of your PHI, please let us know

Please sign below to agree to the terms and disclosures presented to you in this form. Thank you!

X____

Date________________________________

Name__________________
Date___________________

7255 Joshua Lane Suite B
Yucca Valley, CA 92284

Office Policies

Insurance/Billing

As a courtesy, Dr. Chun accepts most primary and secondary PPO insurances. However, it is your responsibility to provide us with complete and accurate insurance or billing information at the time of service. Our office cannot guarantee the amount that an insurance company will pay. Your insurance is a contract between you and the insurance company and we are not a party to this contract. Disputes with insurance companies are the responsibility of the insured. We have no control over the terms of your contract, the method of reimbursement, or the determination of benefits. You agree to be responsible for payment of all services rendered to your child. We will file a pre-determination for recommended treatment, however any pre-determination is only an estimate of insurance coverage. Our office will file your insurance a maximum of two times per appointment. We request that you pay your estimated portion when services are rendered. Any amount not covered by insurance or any difference in the estimated portion is the parent or guardian's responsibility. For your convenience we accept MasterCard, Visa, Discover, check, cash and Care Credit. There will be a monthly maintenance fee of $5.00 on account balances over 60 days old. There will be a $30.00 fee for checks returned by the bank.

Responsible Party

Please be aware that the parent or guardian who signs this consent form is legally responsible for payment regardless of whether or not they are the insurance holder. In the event of separation or divorce, the parent or guardian who signs this form is legally responsible for payment. We cannot send statements to other parties. Reimbursement must be made between divorced parents. We will not intervene.

Scheduling and Missed Appointments

Patients are seen by appointment only. Arriving on time makes it possible for your child to be seen as scheduled. Patients who are running late are asked to call the office as soon as possible to see if they will still be able to be seen. We prefer to see preschool age children during the morning hours whenever possible. For school age children, we have a limited number of after school appointments available. It may be necessary for your child to miss a portion of their school day. Dental appointments are an excused absence from school. A signed excuse for your child's appointment will be provided upon request. Kindly notify us in advance if you are unable to keep an appointment, with a minimum of 24 hours notice. We understand that there are circumstances that may prevent you from keeping your child's appointment. Giving us notice allows us to offer the appointment to other patients awaiting care. We reserve the right to charge a fee of $50 for any missed appointment or under 24 hours notice. Appointments canceled with less than 48 hours notice on a school holiday or an after school time will not be rescheduled on another school holiday or after school, as they are our most popular appointments.

Past Due Accounts

The office cannot carry balances longer than 60 days; regardless if insurance payment is still pending. If the insurance company does not pay the practice within 60 days, we will look to the responsible party for payment. If we later receive payment from the insurer, we will refund any overpayment. If payment has not been received after 90 days, we will inform you of the delinquent account and if no action is taken to clear the account, this office will employ a collection service to collect payment. The responsible party agrees to pay any fees associated with the collection of the account. **I have read and agree to the above Office Policies.**

______________________________	______________________________	______________________
Signature	Printed name	Date

NOTICE TO ALL PATIENTS

Effective January 2, 2024

The Following Appointment Protocol Has Been Established for all Patients

Patients are seen by appointment only. Arriving on time makes it possible for you, your family member, or the person for whom you are responsible, to receive the dental treatment for which you/they were scheduled. Patients who are running late are asked to call the office as soon as possible to determine whether you/they will still be able to be seen. Children should be scheduled during the morning hours whenever possible. For older children, we have a limited number of after school appointments available. It may be necessary for your child to miss a portion of their school day; dental appointments are considered an excused absence from school. A signed excuse for your child's appointment will be provided upon request. Providing the office with advance notice allows us to offer the appointment to other patients awaiting dental treatment.

Please arrive at least 5 minutes before your scheduled appointment time to ensure your planned procedures for the appointment will be completed:

- **You may cancel, or reschedule, your appointment without charge by notifying the office a minimum 48 hours prior to the appointment time**
- **On same day cancellations, or reschedules, your account will be charged 50% of the scheduled service fee(s)**
- **If you do not call in advance as indicated above to cancel your appointment, or simply do not show, your account will be charged the full fee(s) for the scheduled service(s)**
- **If you arrive late to your appointment, your appointment will end at its scheduled time. If you require a second visit to complete your hygiene service(s) and have insurance to be billed, you will be required to pay the fee for that additional appointment**
- **If you arrive more than 8 minutes late to your hygiene appointment, your appointment is subject to re-scheduling**

Authorization for the Release of Dental Records **(if pt requests)**

California

I hereby authorize Joshua Lane Dental, Dr. Chun, DDS to release the information in the dental records of ______________________________ **(patients name)** to

____

(name of Patients Representative)

____

(address)

____

(email address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below

____

____

____

I understand I may receive a copy of this authorization.

______________________________ ______________________

(Patient signature) **(Date)**

If not signed by the patient please indicate the relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Note: this authorization is intended to comply with applicable state laws. It is not intended as a "consent" or "authorization" for the use and disclosure of Protected health information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPPA requirements before releasing the requested records.

Caution: If you intend to use information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (This is 8 point).