Jay J. Sung, D.D.S.

Practice Limited to Endodontics

174 W. College St. • Covina, CA 91723 • Tel 626.915.5317 • Fax 626.966.0244

New Patient Information Form

Mr.❑ Mrs.❑ Ms.❑ Miss❑ Date _____

Patient _____ Birth Date _____ Age _____

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Minor

Address _____

City _____ State _____ Zip Code _____ Phone _____

Patient Employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip Code _____ Business Phone _____

Social Security # _____ Drivers License# _____

If patient is a minor, Name of Responsible Parent or Guardian _____

In case of emergency, please contact: Name _____ Phone Number ( ) _____

Referred by Dentist (name and address) _____

Insurance Information

Person responsible for this account _____ Relationship _____

Address _____ ( ) _____
STREET CITY ZIP TELEPHONE

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO. LOCAL

NAME OF GROUP DENTAL PLAN PLAN NO. NAME OF UNION

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Assignment of Insurance Benefits

I hereby authorize this office to furnish information to insurance carriers concerning treatment and hereby assign to Jay J. Sung, DDS. All payments for dental service rendered. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment to be considered as valid as the original. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I hereby authorize said assignee to release all information necessary to secure payment. A service charge of 1 1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous financial arrangements are agreed upon. As a condition of treatment by this office, financial arrangement must be made in advance. All emergency dental services or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I also understand that the free estimate listed for this case can only by extended for a period of six (6) months from the date of the patient's examination. I agree that a waiver of any breach at any time or condition hereunder shall not constitute waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder, I grant permission to Jay J. Sung, DDS. to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signed _____ Date _____

Treatment and Arbitration Agreement

With regard to dental care and services provided or to be provided at Jay J. Sung, DDS. It is agreed that the attending dentist will provide dental care and services to the patient to the best of their skill and knowledge, in which dental care in the light of circumstances is possible and practical. It is agreed that because of the differences in the human constitution and response, it is no way to warrant the outcome of any dental service.

It is understood that any dispute as to dental malpractice, that is whether any dental service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will de determined by submission to arbitration as provided by California Law and not by lawsuit or resort to court process except as California Law provides for judicial review of arbitration proceedings. Both parties of this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Within fifteen (15) days after a **patient** or **attending dentist** shall give notice to the other of demanding arbitration of such controversy, the parties to the controversy shall each appoint a licensed dentist as arbitrator and give notice of such appointment to the other. Within reasonable time the two arbitrators shall select a licensed dentist as neutral arbitrator and give notice of the selection to the other parties. The arbitrators shall hold a hearing with reasonable time to hear the case before them. All notices and other correspondences shall be served by Certified United States Mail. The arbitration shall be conducted in accordance with and governed by the provision of Title 9 of the California Code of Civil Procedure.

Notice: By signing this contract, you are agreeing to have any issue of Dental Malpractice decided by Neutral Arbitration and you are giving up your right to a jury or court trial.

Dated _____ Patient or Legal Guardian _____

PLEASE COMPLETE BOTH SIDES

Health Information

These questions are for your benefit and assure that treatment will take into consideration you past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

1. Are you in good health? ❑ Yes ❑ No
2. Date of last physical examination? _____
3. Are you under the care of a physician at this time? ❑ Yes ❑ No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ❑ Yes ❑ No
   If so what illness or operation? _____
5. List all medications you are currently taking _____
6. Do you wear a cardiac pacemaker or have you had heart surgery? ❑ Yes ❑ No
7. Have you ever taken Fen-Phen or Redux? ❑ Yes ❑ No
8. Do you smoke? ❑ Yes ❑ No
9. Are you sensitive or allergic to any medication or materials? ❑ Penicillin ❑ Tetracycline ❑ Sulfa drugs
   ❑ Aspirin ❑ Codeine ❑ Latex ❑ Other _____

10. Do you have or have you had any of the following (Please circle Y for yes or N for no.) Answer all conditions.

Y N Anemia	Y N Hay Fever	Y N Head Injuries	Y N Cerebral Palsy	Y N Rheumatic Fever	Y N Sickle Cell Disease	Y N Psychiatric Treatment
Y N Herpes	Y N Glaucoma	Y N Heart Failure	Y N Drug Addiction	Y N Tuberculosis (T.B.)	Y N Cortisone Medicine	Y N Hepatitis or Jaundice
Y N Stroke	Y N Tonsillitis	Y N Scarlet Fever	Y N Kidney Disease	Y N Blood Transfusion	Y N Allergies to Metals	Y N Difficulty Swallowing
Y N Ulcers	Y N Hemophilia	Y N Sinus Trouble	Y N Chemotherapy	Y N Joint Replacement	Y N Excessive Bleeding	Y N Congenital Heart Lesions
Y N Diabetes	Y N Cold Sores	Y N Heart Murmur	Y N Stomach Ulcers	Y N Nervous Disorders	Y N Mitral Valve Prolapse	Y N X-Ray or Cobalt Treatment
Y N Arthritis	Y N Emphysema	Y N Liver Disease	Y N Angina pectoris	Y N Tumors or Growths	Y N High Blood Pressure	Y N Radiation Treatment of any kind
Y N Asthma	Y N Rheumatism	Y N Blood Disease	Y N Mental Disorder	Y N Allergies or Hives	Y N HIV Related Complex	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Cancer	Y N Chicken Pox	Y N Heart Ailments	Y N Thyroid Disease	Y N Pain in Jaw Joints	Y N Respiratory Disease	Y N Acquired Immune Deficiency Syndrome (Aids)
Y N Seizures	Y N Bruise Easily	Y N Heart Attack	Y N Fainting Spells	Y N Artificial Prosthesis	Y N Epilepsy or Seizures	Y N TMJ (Temporomandibular Joint) Disorder

11. (Women) Are you pregnant? ❑ Yes ❑ No
    If so how many months? _____
12. (Women) Do you have any problems associated with your menstrual period? ❑ Yes ❑ No
13. (Women) Do you take any birth control medication or hormones? ❑ Yes ❑ No

Dental History

1. Have you ever had local anesthetic (Lidocaine, etc?) ❑ Yes ❑ No
2. Have you ever had any unfavorable reaction from local anesthetic? ❑ Yes ❑ No
3. **Do you need to be premedicated with antibiotics before any dental treatment?** ❑ Yes ❑ No
   If so, for what? _____
4. Have you ever had any serious trouble associated with any previous dental treatment? _____ ❑ Yes ❑ No
   If so, explain? _____
5. Have you ever had a root canal treatment or dental surgery? _____ ❑ Yes ❑ No

Please check the statement that describes or relates to your dental visit.

Tooth Location? ❑ Upper Right ❑ Upper Left ❑ Lower Right ❑ Lower Left

❑ I am here for treatment of present pain
❑ I never had pain
❑ My dentist said I need a root canal
❑ My dentist worked on the tooth
When _____
❑ I had my teeth straightened
❑ I had an accident involving my mouth
❑ I noticed pain _____ ago
❑ The pain is steady
❑ The pain occurs spontaneously
❑ The pain is localized in one tooth
❑ I have a gum blister or boil
❑ The pain increases with cold
❑ The pain increases with heat
❑ I had surgery on this tooth
❑ The pain is spreading
❑ I am presently on antibiotics
❑ I am taking pain medication

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ **Signature of patient or guardian** _____

Date _____ **Reviewed by Dr.** _____ **Updated** _____

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

OUR LEGAL DUTY

We are required by applicable federal and state law 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 (04/14/03), and will remain in effect until we replace it.

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 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 use and disclose health information about you for treatment, payment, and healthcare operation. For example:

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

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

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 other person to the extent necessary to help with your health care or with payment for your healthcare, 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 involvement in your healthcare. We will also use our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, 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 practicable 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 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 copies, we will charge you $0.25 for each page, $12 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end 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 you 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 to 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 website 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 you 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support the 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 Officer: Maria Palestino

Telephone: (626) 915-5317 **Fax:** (626) 966-0244

Address: 174 West College St. Covina, CA 91723

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CONSENT FOR SERVICES

I_____ have been advised by my Dr. _____ (my referring dentist) that I require root canal procedure on tooth#_____.

I understand that root canal treatment is an attempt to save my tooth due to loss of vitality from infection, decay, crack, or to obtain sufficient retention for restoration. The alternative to root canal therapy is extraction.

Root canal procedures are very safe and effective; nonetheless some risks and complications that may arise are as follows:

1. Root canal procedure requires anesthesia and multiple radiographs (x-rays).
2. Local anesthesia injection sometimes causes trismus (difficulty in jaw opening) or paresthesia (temporary or permanent loss of sensation).
3. Post-operative discomfort or swelling, lasting a few hours to several days, for which medication will be prescribed if deemed necessary by the doctor.
4. Allergic reactions to medication or anesthetics.
5. Separation of root canal instruments during treatment which may, in the judgment of the Doctor, be left in the treated root canal or require surgical procedure for removal.
6. Perforation of the root canal due to curved roots or existing conditions. This may require additional surgical treatment or extraction.
7. Premature tooth loss may result from cracks or fractures that can occur during the root canal therapy or from progressive periodontal gum disease.
8. Access through a crown or bridge (existing restorations) may result in damage to restorations, which is not the responsibility of your endodontist.
9. Treatment may be discontinued due to calcified canals, accidentally broken files or reamers, or fracture of root or crown.
10. Success rate of root canal procedures is considered very high. (If failure occurs the treatment may have to be redone, surgerized, or extracted).
11. Post-surgical complications include: discomfort and pain, swelling, bruises, excessive bleeding, trismus, and injury to the nerve underlying the teeth which may result in numbness or tingling of the lip, chin, gums or tongue on the operated side. This may persist for several weeks, months, or in remote instances permanently. Also, there may be exposure of the sinus in the upper teeth.
12. The crown of the tooth may darken eventually and/or become brittle due to loss of vitality. We recommend placement of a crown or any other proper restoration determined by your referring doctor as soon as possible.

I understand that at any time during treatment, medications may be prescribed that may have side effects such as nausea and diarrhea. If any adverse side effects such as itching, rash or hives occur, I am to stop the medication and call the doctor who prescribed them.

I understand that failure to continue with initiated treatment may result in the eventual loss of the tooth through decay, fracture, or extraction. If this occurs, I can not hold the doctor who initiated the treatment responsible.

I understand that doing root canal therapy through crowns may hide existing decay or cracks, that are not visible to the doctor, and therefore I cannot hold the doctor responsible for missing them.

I understand that after my root canal procedure is completed I should go back to my general dentist to continue my treatment by placing a proper restoration on the tooth.

Please do not hesitate to ask any questions in regards to the procedures being performed.

Patient or Legal Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Patient Number _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of or protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy or our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Maria Palestino

Telephone: (626) 915-5317 **Fax:** (626) 966-0244

Address: 174 West College St. Covina, CA 91723

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, Have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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626-915-5317

Patient Name: _____

	Date:	Date:	Date:
Do you have fever (>100.4 F) or have you felt hot or feverish recently (14-21 days)	Yes No	Yes No	Yes No
Are you having shortness of breath of other difficulties breathing?	Yes No	Yes No	Yes No
Do you have a cough?	Yes No	Yes No	Yes No
Have you recently lost or had a reduction in your sense of smell or taste?	Yes No	Yes No	Yes No
Are you experiencing chills or repeated shaking with chills?	Yes No	Yes No	Yes No
Do you have other flu-like symptoms, such as headache, runny nose, fatigue?	Yes No	Yes No	Yes No
Have you been tested for COVI-19 in the last 14 days? If so what were the results?_____	Yes No	Yes No	Yes No
Are you in contact with any confirmed COVID-19 positive patients? *Patient who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	Yes No	Yes No	Yes No
Have you traveled more than 100 miles from your home in the last 14 days	Yes No	Yes No	Yes No

Patient's Signature:_____ Date: _____