Dr. Hyun Bang, DDS

Family Cosmetic Implant Laser Invisalign Dental Sleep Medicine

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

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 some 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: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

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

P. 415-771-2150 F. 415-484-7852
2001 Van Ness Ave Ste 401, San Francisco, CA 94109
smileinfo@drhyunbang.com
www.drhyunbang.com

Medical Information **Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐

Date:_____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐

Date Treatment began: _____

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

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

WOMEN ONLY Are you:

Pregnant? Yes ☐ No ☐ DK ☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐

Nursing? Yes ☐ No ☐ DK ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐ DK ☐

Name of physician or dentist making recommendation:

Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐ DK ☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and 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 his/her 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 other member of his/her 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/Legal Guardian: Date:

Signature of Dentist: Date:

Update:

Signature of Patient/Legal Guardian: Date:

Dr. Hyun Bang, DDS
Family Cosmetic Implant Laser Dental Sleep Medicine

Dental Sleep Information:

Your sleep impacts every aspect of your life and your general and oral health. Sleeping well helps you look, feel and perform your best. But a sleep problem can be harmful to your health and well-being. One of the most common sleep problems is obstructive sleep apnea. The below screening tool will help give Dr. Bang information needed to make appropriate referrals and recommendations.

Current Therapies:

□ **Yes** □ **No** □ **N/A** Have you attempted CPAP therapy?
□ **Yes** □ **No** □ **N/A** If yes, are you able to use it at least 5 nights a week (4 or more hrs per night)?
□ **Yes** □ **No** □ **N/A** Have you undergone any surgical attempts to correct your sleep apnea? □ Yes □ No
□ **Yes** □ **No** □ **N/A** Have you tried any of the following conservative methods of improving your sleep breathing? (Please check)
- □ Weight loss
- □ Positional therapy: Avoiding sleeping on your back during sleep (the supine position)
- □ Abstaining from the use of alcohol and/or sedatives before bedtime
- □ N/A

STOP/BANG Scoring Tool

Do you **S**nore loudly?	Yes / No
Do you often feel **T**ired, fatigued, or sleepy during daytime?	Yes / No
Has anyone **O**bserved you stop breathing during your sleep?	Yes / No
Do you have, or are you being treated for high blood **P**ressure?	Yes / No
BMI more than 35? (see BMI chart, height (in.) _____ weight (lbs.) _____)	Yes / No
Age – Over 50yrs old?	Yes / No
Neck circumference greater than? (17"/43cm male or 16"/41cm female)	Yes / No
Gender – Male?	Yes / No

High risk of OSA: Yes 5 – 8, Intermediate risk of OSA: Yes 3 – 4, Low risk of OSA: Yes 0 - 2

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep during the day? Use the following scale to choose the most appropriate number for each situation. (Please circle the number to answer.)

ACTIVITY:	Never doze	Slight Chance	Mod Chance	High Chance
Sitting and Reading	0	1	2	3
Sitting inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
SUBTOTALS:				
TOTAL(add subtotals):				

1-6	**Congratulations, you are getting enough sleep!**
7-8	**Your score is average**
9 and up	**Seek the advice of a sleep specialist without delay**

Citation for CPAP compliance as 5 nights a week for 4 or more hours each night (4 or more hours a night for 70% of nights): ocal Coverage Artide for FAQs- Positive Airway Pressure Devices (A48132). www.cms.gov. J Clin Sleep Med 2011;7(5):467-472 Ill. Johns MW. A new method for measuring daytime sleepiness: Epworth sleepiness scale. Sleep 1991;14:540-5

Dr. Hyun Bang, DDS
Family Cosmetic Implant Laser Dental Sleep Medicine

Dental Insurance Information

Primary Carrier
Insurance co. name_____
Insurance co. number_____ Group no. _____
Address (Street, City, State, Zip) _____
Insured's ID no. _____ Insured's name_____
Relationship to patient_____ Date of birth_____
Insured's social security no. _____
Insured's employer name_____
Is insured a patient in our practice? □ Yes □ No

Secondary Carrier
Insurance co. name_____
Insurance co. number_____ Group no. _____
Address (Street, City, State, Zip) _____
Insured's ID no. _____ Insured's name_____
Relationship to patient_____ Date of birth_____
Insured's social security no. _____
Insured's employer name_____
Is insured a patient in our practice? □ Yes □ No

Medical Insurance Provider_____

Person Financially Responsible for Account
Name (Last, First) _____
Relationship to Patient_____
Social security no. _____ Date of birth_____
Home Phone_____ Driver's License _____
Address (Street, City, State, Zip) _____
Employer_____
Work phone_____ Cell phone_____
Preferred payment method (please check one): □ Cash □ Check □ Credit Card
Visa/MC no. _____Exp date_____
If patient is a minor, name of parent or legal guardian_____
Relationship to patient: _____
Is this a parent or legal guardian currently a patient in our office? □ Yes □ No

Office Policy

Payment is due in full at the time of treatment (Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature of Patient/Legal Guardian: _____ Date: _____

Dr. Hyun Bang, DDS
Family Cosmetic Implant Laser Dental Sleep Medicine

Acknowledgement of Receipt of Notice of Privacy Practices (You may refuse to sign this acknowledgement)

I, (print patient name) _____, have received from **Dr. Hyun Bang** a copy of this office's Notice of Privacy Practices.

Signature of Patient/Legal Guardian: _____ Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (check one)

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify) _____

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, (print patient name) _____, have received from **Dr. Hyun Bang** a copy of the Dental Materials Fact Sheet dated May 2004.

Signature of Patient/Legal Guardian: _____ Date: _____

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA website does not constitute an endorsement of the content of this document.

We welcome you as a patient member of our dental healthcare team.
We will do our very best to provide quality care.
We are open to comments, complaints, and suggestions.
Please do not hesitate to let us know of ways we can improve.

Dr. Hyun Bang and Team
Ruby, Sandy RDA, Arlene, Stephanie RDH

Office Use Only

I verbally reviewed the dental medical office policy information above with patient named herein.

Staff Initial:_____Date:_____

Dr. Hyun Bang, DDS
Family Cosmetic Implant Laser Dental Sleep Medicine

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATI ON ABOUT YOU MAY BE USED ANO
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIO
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEAL TH INFORMATION JS 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 April 14, 2003, 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 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider pro viding treatment to you.
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, and 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 other 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.
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 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 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 tinder 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).

Notice of Privacy Practices (continued)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. The records being requested are a property of Hyun S. Bang, DDS, and under HIPAA laws we are given the right to charge a fee for duplication, and patients must use the provided form to authorize the release of records. In order to be fair to patients who only desire to duplicate a small number of records, our fee ranges from $30-$50 but will not exceed $50. We will use the format you request for duplication 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 f information listed at the end of this notice for the protection of your privacy. Contact us using the information listed at the end of this notice for other questions.)
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 from today's date. 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 V 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 alternati1 ·e 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 (smlieinfo@drhyunbang.com), 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. 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 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 Officer: Hyun Bang, DDS
Telephone: 415-771-2150
Fax: 415-484-7852
Email: smileinfo@drhyunbang.com
Address: 2001 Van Ness Ave Ste 401, San Francisco, CA 94109