# Katherine T. Vo, D.D.S., Inc

450 Sutter Street, Suite 2525
San Francisco, CA 94108
p: 415.397.1004
f: 415.397.3060
info@kvodental.com
www.kvodental.com

## Welcome to our practice!

We'd like to thank you for choosing our office to care for your dental needs. This file contains the following forms and information:

- New patient information
- Office appointment and financial policies
- Notice of privacy practices

Please complete and sign the patient information questionnaire and read and sign our office appointment and financial policies so that we may provide you with the best possible care. All information is completely confidential.

Also included for your information only is a copy of our Notice of privacy practices, which federal law requires all health care providers to give to a patient.

**Please do not forget to bring the completed and signed forms to your first visit!**

If you have any questions, please call our office at 415.397.1004 or email us at info@kvodental.com.

Sincerely,

Katherine Vo Cook, DDS

## Patient Information

Please complete and sign the following questionnaire so that we may provide you with the best possible care. All information is completely confidential.

### Getting to Know You as Our Patient

TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____

MAILING ADDRESS _____ APT/UNIT _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ MOBILE _____

EMAIL _____

BIRTHDATE _____ SSN _____ DRIVER'S LICENSE / STATE _____

GENDER ☐ M ☐ F

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SPOUSE'S NAME _____

YOUR EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE COMPANY _____ GROUP _____ SUBSCRIBER _____

SECONDARY INSURANCE COMPANY _____ GROUP _____ SUBSCRIBER _____

How did you hear about our office? (Check only one)

Referred by: ☐ FRIEND ☐ INSURANCE ☐ ZOCDOC ☐ OTHER: _____

### Responsible Party (if different from above)

NAME _____ RELATIONSHIP TO PATIENT _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ MOBILE _____

BIRTHDATE _____ SSN _____ DRIVER'S LICENSE / STATE _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

### Emergency Contact

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE: HOME _____ WORK _____ MOBILE _____

NAME OF YOUR MEDICAL DOCTOR _____ PHONE _____

## Consent

I will answer all health questions to the best of my knowledge: _____
(your initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

X_____ _____ _____
Signature Date Relationship to patient

## Patient's Dental History

Reason for today's visit? (Pain, checkup, etc.) _____

Previous dentist_____ Last visit_____ Last cleaning _____

Reasons for changing dentists _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ No ☐ Yes, because _____

How often do you brush?_____ Do you floss? ☐ No ☐ Yes How often? _____

Please answer Yes or No to the following statements:

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ☐ | ☐ | I grind my teeth during the day / while sleeping. | ☐ | ☐ | My gums feel tender or swollen. |
| ☐ | ☐ | My gums bleed while brushing or flossing. | ☐ | ☐ | I have problems eating. |
| ☐ | ☐ | I like my smile. | ☐ | ☐ | I have had orthodontics. |
| ☐ | ☐ | I prefer tooth-colored fillings. | ☐ | ☐ | I have had a facial or jaw injury. |
| ☐ | ☐ | I avoid brushing part of my mouth due to pain. | ☐ | ☐ | I want my teeth straight. |
| ☐ | ☐ | I want my teeth whiter. | | | |

What are your dental priorities (e.g., dental health, financial considerations, etc.)?

_____

## Patient's Medical History

I consider my health to be (please check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Which medications are you currently taking? (Check all that apply.)

☐ Nerve pills ☐ Muscle relaxers ☐ Blood thinners ☐ Insulin
☐ Pain killers ☐ Stimulants ☐ Tranquilizers

☐ Other, please list: _____

Have you ever taken the following? (Check all that apply.)

☐ Bisphosphonate or any other osteoporosis medications (e.g., Aredia / Fosomax) ☐ Fen-Phen or Redux

Do you have or have you had any of the following? (Check all that apply.)

- ☐ 1. Heart Disease
- ☐ 2. Heart Murmur / Mitral Valve Prolapse
- ☐ 3. Stroke
- ☐ 4. Congenital Heart Lesions
- ☐ 5. Rheumatic Fever
- ☐ 6. Abnormal Blood Pressure
- ☐ 7. Anemia
- ☐ 8. Prolonged Bleeding Disorder
- ☐ 9. Tuberculosis or Lung Disease
- ☐ 10. Asthma
- ☐ 11. Hay Fever
- ☐ 12. Sinus Trouble
- ☐ 13. Epilepsy / Seizures
- ☐ 14. Ulcers
- ☐ 15. Implants / Artificial Joints Hip Knee Other
- ☐ 16. Liver Disease
- ☐ 17. Jaundice
- ☐ 18. Hepatitis Type _____
- ☐ 19. Diabetes
- ☐ 20. Excessive Urination and / or Thirst
- ☐ 21. Infectious Mononucleosis (Mono)
- ☐ 22. Herpes
- ☐ 23. Arthritis
- ☐ 24. Sexually Transmitted/Venereal Disease
- ☐ 25. Kidney Disease
- ☐ 26. Tumor or Malignancy
- ☐ 27. Cancer / Chemotherapy
- ☐ 28. Radiation Treatment
- ☐ 29. History of Drug Addiction
- ☐ 30. HIV / AIDS
- ☐ 31. Immune Suppressed Disorder
- ☐ 32. Hearing Loss
- ☐ 33. Fainting Spells
- ☐ 34. Glaucoma
- ☐ 35. History of Emotional or Nervous Disorders

Do you have any other medical problem or medical history NOT listed on this form? ☐ No ☐ Yes, I have / had:

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Have you had any major surgeries? ☐ No ☐ Yes, I had surgery:

Year_____Type of operation _____

Year_____Type of operation _____

Are you allergic to any of the following? (Check all that apply.)

- ☐ Latex / Metals / Plastics
- ☐ Penicillin
- ☐ Codeine
- ☐ Aspirin / Ibuprofen
- ☐ Sulfa Drugs / Sulfites / Sulfides
- ☐ Local Anesthetics (Novocaine)
- ☐ Other Medications: _____

Do you smoke or use tobacco? ☐ No ☐ Yes How much per day?_____How many years? _____

**FOR WOMEN:** Are you taking birth control medication? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes How long? _____

*** I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this

Information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

X_____ _____ X_____ _____

**Patient (or Guardian's) Signature** Date **Doctor's Signature** Date

# Office Policies

If you have any questions about the following policies do not hesitate to ask us. We will be glad to answer your questions. Good communication is the key to excellence in healthcare. In case of questions contact our office at 415.397.1004.

## Appointment Policy

We strive to see all patients on time for their scheduled appointments. There are times when our schedule is delayed in order to accommodate an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if you need emergency treatment.

- Please plan to arrive 10 minutes prior to your scheduled appointment to allow time to complete any additional paperwork.
- If you arrive 15 minutes or more late for your appointment, you may be asked to reschedule for the next available appointment time.
- Broken or missed appointments affect many people. We try to remind patients by telephone prior to appointments, but **please do not depend on this courtesy.** We reserve the right to charge for office visits cancelled or broken without 48-hour advance notice.
- The broken appointment fee is $75.

Thank you for your cooperation.

## Financial Policy

### Payments

I understand that treatment **fees are due at time of service**. As a courtesy, treatment claim will be billed to my insurance. It is the patient's responsibility to know your coverage; if the patient does not know they are welcome to ask a member of the office staff, and they can help.

### Insurance

The insurance company, not Katherine T. Vo, D.D.S. Inc., determines the dental benefits you will receive. Insurance is an agreement between the patient and the patient's insurance company. **I am responsible for the balance of my dental account regardless of your insurance coverage.** Our office will provide a close ESTIMATE based on standard insurance coverage of 100%, 80%, 50%. It is the patient's responsibility to know if the treating dentist is a participating provider on their plan and/or if they are allowed out-of-network benefits.

### Financial Arrangements

Katherine T. Vo, D.D.S., Inc. understands the difficulty of financing major treatment. For your convenience our office offers multiple forms of financing and methods of payment. These include: Credit cards (VISA, Master Card, American Express, and Discover Card), Debit cards, and Cash. It is the patient's responsibility to make the financial arrangements with our office **prior to** the appointment**,** if payment cannot be made in full at time of service.

I authorize the office of Katherine T. Vo, D.D.S., Inc., to submit insurance claims on my behalf. Insurance benefits will be paid directly to the patient.

I recognize that all payments due are my legal responsibility and are due at time services are rendered, and that delinquent accounts will be sent to a collection agency. All delinquent accounts will be charged an interest rate of 1.5% (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and attorney fees.

I have read and understand the above policies. I have had the opportunity to ask questions concerning any of these matters and they have been answered to my satisfaction. I understand a 48-hour notice is required on all cancellations; all other cancellations or "no shows" will incur a rescheduling fee of $75.

_____
Print Name

X_____ _____
Signature Date

## NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Responsible party:

I,_____, have received and read a copy of this office's Notice of Privacy Practices.
(Please print your name)

X_____ _____
Signature Date

**For Office Use Only**

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify) _____

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 described in this Notice while it is in effect. This notice takes effect immediately 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 disclose or use 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 a payment for services we provided you.

**Healthcare Operations:** We may use and disclose your health information in connection with our 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use or discloses permitted by your authorization while it was in effect. Unless you give us 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 Patients 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.

**Person 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 to your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up the filled prescriptions, medical supplies, xrays, or other similar forms of health information.

**Marketing and 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 and email messages, texts, 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 practically 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 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 top of this Notice. If you request copies we will charge you 25 cents per page, $30.00 per hour of 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 disclose your health information for purposes, other than that of treatment, payment, healthcare operations and certain other activities. 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 to alternative locations. Your request must be in writing and specifies the alternative means or location, and provides satisfactory explanation how payments will be made 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.

## QUESTIONS AND COMPLAINTS

If you have any questions or concerns about our privacy practices please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have 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 alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health Services upon request.

We support your right to 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:

Katherine Vo Cook, D.D.S
450 Sutter Street, Ste 2525
San Francisco, CA 94108
p: 415.397.1004
f: 415.397.3060