

TO OUR VALUED PATIENT:

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff.

Payment for services are due at the time services are rendered. We accept cash, checks, Visa, Mastercard, or Carecredit. We will submit an insurance claim on your behalf if you show proof of coverage. Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill. If your insurance coverage/company changes, it is your responsibility to notify our office immediately in writing.

**YOU MUST UNDERSTAND THE FOLLOWING:**

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are to a party to that contract! Our relationship is with you, the patient. It is your responsibility to see your insurance pays on time. Your copayments/deductibles are due at the times of treatment.
2. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that **NOT ALL SERVICES ARE A COVERED BENEFIT** in all insurance policies. You are responsible for knowing, per your insurance plan, what services are or are not covered. Fees for these services, along with any unpaid deductible and copayments are due at the time of treatment.
3. You are responsible for knowing your insurance benefits. Is Pre-authorization required for any treatment exceeding \$300? Does your secondary insurance have a non-duplication of benefits clause? What is your annual maximum of benefits? At any time, you may request a list of all your transactions, so you may be aware of what amount of benefits you have remaining. If we can be of any assistance, please let us know.
4. If your insurance company does not pay in full within 45 days, we ask you contact your insurance company to check status. If any claims are not paid by your insurance company within a reasonable time period, we ask you to pay the balance due. We expect prompt payment from you within 10 days of statement received for any balance due after insurance pays.
5. Returned checks are subject to a \$25 returned check fee.
6. Any unpaid charges over 90 days old may be subject to interest charges of 1.5% per month and further collection action by an outside agency unless other payment arrangements have been made in writing.
7. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees or court costs. It is your responsibility to notify of any changes in your address or phone number.
8. No minor children (under the age of 18 years old) will be treated without a parent present DURING treatment.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status or any of the above information.

\_\_\_\_\_  
Signature of Patient/Responsible

\_\_\_\_\_  
Party Print Patient's Name

\_\_\_\_\_  
Date:

**Consent to the Use and Disclosure of Health Information For Treatment,  
Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

9. a basis for planning my care and treatment
10. a means of communication among the many health professionals who contribute to my care
11. a source of information for applying my diagnosis and treatment information to my bill
12. a means by which a third-party payer can verify that services billed were actually provided
13. and a tool for routine healthcare operations

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change their notice and practices according to the guidelines established by law. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent regarding actions that this office has already acted upon.

In addition to the above mentioned agencies I will allow release of my personal information to:

I request the following restrictions of my personal information:

Name (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

POINT NORTH DENTAL  
RAY KIM, DDS  
<http://www.drraykim.com>

7312 West cheyenne Ave. Suite 3  
Las Vegas, NV 89129  
(702)396-9924

Dear Patient:

If you are unable to keep a scheduled appointment, we do **REQUIRE A 24 HOUR NOTICE.** Otherwise we reserve the right to charge a fee of \$25.00 or more for the time reserved. Thank you for your cooperation

Name (Please Print)\_\_\_\_\_

Signature:\_\_\_\_\_

Date:\_\_\_\_\_

*Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us*

**Patient Information**

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Please circle one of the following: Minor Single Married Divorced  
If patient is a student, Name of school/college \_\_\_\_\_  
Person to Contact In Case Of Emergency \_\_\_\_\_ Phone( ) \_\_\_\_\_  
**Whom may we thank for referring you ?** \_\_\_\_\_

**Responsible Party**

Name of person \_\_\_\_\_ Relation \_\_\_\_\_  
responsible for this account \_\_\_\_\_ to Patient \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Is the responsible party in our office ? Yes No

**Insurance Information**

Name of insured \_\_\_\_\_ Relation \_\_\_\_\_  
to Patient \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone( ) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Member # \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
What is your maximum calender/contract benefit ? \_\_\_\_\_  
How much is your deductible ? \_\_\_\_\_ Have you used any benefits or  
met your deductible for this calendar / contract year ? \_\_\_\_\_

**Additional (Secondary) Insurance**

Name of Insured \_\_\_\_\_ Relation \_\_\_\_\_  
to Patient \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone( ) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Member # \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
What is your maximum calendar / contract benefit ? \_\_\_\_\_  
How much is your deductible ? \_\_\_\_\_ Have you used any benefits or  
met your deductible for this calendar / contract year ? \_\_\_\_\_

**Authorization and Release**

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

**Information Update**

14. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
1. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
1. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

# Dental History

Patient Name: \_\_\_\_\_

Reason for Today's visit \_\_\_\_\_  
Former Dentist \_\_\_\_\_

Date of last Dental Exam ? \_\_\_\_\_  
Date of las Dental x-rays ? \_\_\_\_\_

Check if you had any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bad Breath            | <input type="checkbox"/> Grinding Teeth          | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Bleeding gums         | <input type="checkbox"/> Sensitivity to cold     | <input type="checkbox"/> Clicking or popping jaw        |
| <input type="checkbox"/> Sensitivity to hear   | <input type="checkbox"/> Sensitivity to sweets   | <input type="checkbox"/> Food collection between teeth  |
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Sores / growths in your mouth  |

How often do you brush ? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Are you happy with your smile ?  Yes  No, if No Why ? \_\_\_\_\_

## Medical History

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, adipez, fastin (brand names of phentermine), pondimin (fenduramine) and redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations ?  Yes  No if Yes, describe \_\_\_\_\_

Have you ever had a blood transfusion ?  Yes  No If yes, approximate date \_\_\_\_\_

(Women) Are you pregnant ?  Yes  No Nursing ?  Yes  No

Taking Birth Control Pills ?  Yes  No

Check if you had any of the following:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Cortisone treatment     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Cough persistent        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Short Breath               |
| <input type="checkbox"/> Cough up blood   | <input type="checkbox"/> HIV / AIDS              | <input type="checkbox"/> Skin Rash           | <input type="checkbox"/> Artificial joints          |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Jaw Pain                | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma                     |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Back Problems       | <input type="checkbox"/> Fainting                   |
| <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Glaucoma                   |
| <input type="checkbox"/> Tobacco Habit    | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Pace Maker                 |
| <input type="checkbox"/> Tonsillitis      | <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Radiation Treatment        |
| <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Disease        |
| <input type="checkbox"/> Ulcer            | <input type="checkbox"/> Circular Problems       | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Swelling of feet or Ankles |

Medications:

List any Medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

Allergies:

\_\_\_\_\_

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Signature of patient or parent if minor

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Date

**Information Update**

- 15. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_
- 2. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_
- 2. Patient's signature \_\_\_\_\_ Date \_\_\_\_\_