NAPPY LAM, D.D.S. 5720 SE Foster Road Portland, OR 97206 (503)771-2212

PATIENT INFORMATION
(Please complete this form prior to your appointment. Thank you)

A. Name:_____ _____ _____ Date of birth:_____
Last First Middle
Home Address:_____ _____ _____ _____
Street city state zip code
Home Phone:( )_____ - _____ Cell phone:( )_____ - _____
Email address:_____ Driver's License #:_____
Social Security #:_____ - _____ - _____
Employer:_____ Occupation:_____
Employer Address:_____ _____ _____ _____
Street city state zip code
Work Phone Number:( )_____ - _____
Best way to contact you: Home phone:____ Cell phone:____ Work phone:____ Email:____
Marital Status(check one): Single____ Married____ Divorced____ Separated_____

B. If someone other than the patient is responsible for payment, please complete the following:
Name of the responsible party_____ Social Security #:_____ - _____ - _____
Relationship to patient:_____ Home Phone:( )_____ - _____
Cell phone: ( )____-_____Employer:_____ Work phone:( )____-_____

C. In case of Emergency:
Relative to contact (other than spouse)_____ Phone ( ) _____ - _____
Other person to contact (not a relative) _____Phone ( ) _____ - _____

D. Insurance information:
Name of insured:_____ DOB:_____SS#:_____
Primary Insurance Co. _____ Address_____
Phone #:_____Group #:_____ID#:_____

Name of insured:_____ DOB:_____SS#:_____
Secondary Insurance Co. _____ Address_____
Phone #:_____Group #:_____ID#:_____

F. Please sign and return to the receptionist:

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Signature:_____ Date:_____

Nappy Lam DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 your protected health information to carry out treatment, payment activities, and healthcare 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, and of other important matters about your protected health information. A copy of 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 Person: Annette Lam
Telephone: (503) 771-2212 Fax: (503) 774-7128
Email: nappylamdds@yahoo.com
Address: 5720 SE Foster Road, Portland, OR 97206

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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart

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: _____

Nappy Lam DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date: _____

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 physician's care now?	○ Yes	○ No	If yes, explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, explain: _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, explain: _____
Are you taking any medications, pills or drugs?	○ Yes	○ No	If yes, explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	_____
Are you on a special diet?	○ Yes	○ No	_____
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other
If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Rheumatism	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	Shingles	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Stroke	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Ulcers	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

PATIENT DENTAL HISTORY

Patient's Name: _____Date of Birth: _____

How often do you brush your teeth? _____How often do you floss? _____

Is your drinking water fluoridated? (circle one) YES NO

Do your gums bleed while brushing or flossing?	Y	N	Do you have frequent headaches?	Y	N
Are your teeth sensitive to hot or cold liquids/foods?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Have you had any head, neck or jaw injuries?	Y	N	Have you noticed any loosening of your teeth?	Y	N
Have you ever experienced any of the following problems in your jaw?	Y	N	Have you ever worn a night guard or any other appliance?	Y	N
Clicking	Y	N	Do you wear dentures or partials?	Y	N
Pain (joint, ear, side of face)	Y	N	If yes, date of placement : _____		
Difficulty in opening or closing	Y	N	Have you ever had any prolonged bleeding following extractions?	Y	N
Difficulty in chewing	Y	N			

Smile Evaluation:

1. Do you like the way your teeth look now? (circle one) YES NO
   Please explain:
2. Are you happy with the color of your teeth (would you like your teeth to be whiter)? YES NO
   Please explain:
3. Would you like your teeth to be straighter: YES NO
   Please explain:
4. Do you have spaces between your teeth that you would like to be closed? YES NO
   Please explain:
5. Do you like the shape of your teeth: YES NO
   Please explain:
6. Do you have missing teeth you would like replaced? YES NO
   Please explain:
7. Do you have old silver fillings that you would like to have replaced with tooth colored fillings? YES NO
   Please explain:
8. If you could change anything about your smile, what would you change?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Signature of Patient (or legal guardian, if minor) Date

Nappy Lam DDS
5720 SE Foster Rd
Portland, OR 97206
(503) 771-2212

Financial and Appointment Policy

Usual and Customary Fees: While our fees are comparable to fees charged by other dentists in this area, **they are not necessarily the same as what your insurance company considers as "usual and customary."**

Insurance: If you are using dental insurance, please note that your benefit plan is generally a contract between your employer (or plan sponsor), and your insurance company. Your dental plan is designed to share in your dental costs and the designated percentages covered may not be equal to that portion of the actual fee charged (usual and customary).

As a courtesy to you, we will be glad to prepare and submit your insurance claims; however, any follow up after 60 days will become patient responsibility. The patient is ultimately responsible for the bill and/or any unpaid balance after the insurance has paid.

PAYMENT POLICY: Payment in full is due at the time of service, unless other financial arrangement have been made prior to the date of appointment. If you have dental coverage, your estimated portion will be expected at the time of service.
We accept cash, check or credit card payments. Outside financing is also an option. We have applications in our office.
Returned checks will be subject to a $40.00 returned check fee.

APPOINTMENTS: Your appointment time has been reserved specifically to meet your dental needs for that visit; therefore, if you are unable to keep your appointment, please give us at least 24 hours notice or you may be charged a missed appointment fee of up to $100.00

TREATMENT FOR MINOR CHILDREN (UNDER AGE 16): Unless other arrangements have been made prior to the appointment, the minor child's parent(s) or guardian(s) must accompany the child.

FINANCE CHARGES: A finance charge of 18% APR or 1.5% per month will be incurred for any account balance that is not paid within 90 days from the date of service.
I acknowledge that I am financially responsible for all charges incurred whether or not they are covered by insurance. I assign any insurance payments to be paid directly to Nappy Lam DDS, which would otherwise be payable to me. I also authorize the release of any information, including diagnosis and treatment records to my insurance company.

Name (please print): _____

Signature: _____ Date: _____

Nappy Lam DDS

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 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 providing 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, 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 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.

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 pickup 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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 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 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 $1.00 for each page, $5.00 per hour for staff time to locate and copy your healthy 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 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**. {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 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: Annette Lam
Telephone: (503) 771-2212 **Fax:** (503) 774-7128 **Email:** nappylamdds@yahoo.com
Address: 5720 SE Foster Rd, Portland, OR 97206

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to Sign this Acknowledgement *

I, _____, have received a copy of Dr. Nappy Lam's Notice of Privacy Practices.

If you are a responsible party, please include your name as well as names of all minor children that will be seen by Dr. Lam:
Name (s): _____

Signature: _____ Date:_____

☐ Refusal to sign Acknowledgement