Maple Leaf Dental

Jia Wang, DDS | Kyung Cho, DDS

AUTHORIZATION FOR RELEASE OF RECORDS

to release information and x-rays contained in my dental records from:

I, ____, hereby authorize:

(dentist/clinic name)____

(address)____

(city, state, zip)____

(phone/fax number)____

and send my dental records to:

Jia Wang, D.D.S. PLLC
7750 15th Avenue NE, Suite A
Seattle, Washington 98115
office@mapleleafdental.com

Information requested: Full mouth/panoramic x-rays if less than 5 years old, most recent bitewings, periodontal charting, date and type of the last dental cleaning and any other information or reports that would be useful for future treatment.

Dr. Wang is hereby released from all legal responsibility or liability for the release of the above-mentioned disclosure of information.

I understand that I have the right to withdraw this authorization at any time, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation will expire 90 days from the date of signature.

Signature of
Patient____

Printed Name of
Patient____

Date_____________________________________

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Notice of Privacy Practices Acknowledgement

We keep a record of the private health information and health services we provide for you. We use your information for your dental care. You may request to see, receive, and/or make corrections to that record. **We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.** Your information can and will be used to conduct, plan, and direct your treatment and follow-up among multiple healthcare providers who may be involved in treatment directly or indirectly and to obtain payment from third-party payors. *If we use your information for any other purpose, we must inform you.*

For all requests regarding your personal health information/record, including access to a copy, lodging a complaint, request for accounting of disclosure, requests to amend your patient record, or more information regarding Maple Leaf Dental's Privacy Practices, contact the Privacy Officer Dr. Jia Wang at (415) 623-0903.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our **Notice of Privacy Practices**.

My signature confirms I acknowledge access to the **Notice of Privacy Practices** and have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act (HIPAA) of 1996.

Additional Disclosure of Authority

In addition to allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorized disclosure of my protected health care information in the following way: (initial all that apply)

_______Cell phone ________Personal email

_______Land line ________OK to leave a message with someone who may answer the phone

_______Work phone ______ Work email

_______Text

_______Family member only

_______other (please specify) ________________________________

Patient Name:____ Date: ________________

Signature:____

Relationship to Patient:____________________________________

Dependent Family members are also covered by this acknowledgement.

MLD staff: If not signed, please document why.

Maple Leaf Dental

7750 15th Ave NE, Suite A, Seattle, WA 98115 (206) 402-3402 office@mapleleafdental.com

Name: ____ Preferred Name: __________________
(Last) (first) (middle initial)

Preferred pronoun:________________ Single: __ Married: __ Partner's Name: ________________________________

Date of Birth: ____________ Soc. Sec.#: ______________________ Parent : _____________________________(if minor)

Address: ____ City: ___________________ State: _____ Zip: _________

Cell: (____) ___________________ Work: (____) ______________________LandLine: (____) _________________

Email: ____ Referred by: _________________________________

Employer: ____ Occupation: _________________________________

INSURANCE INFORMATION

Primary Dental Insurance: ____________________________________

Employer & Group #: ____

Name of Subscriber (other than self): _____________________________

DOB: _________ SS#: _______________ Ins. ID#___________________

Secondary Dental Insurance: ___________________________________

Employer & Group #: ____

Name of Subscriber (other than self): _____________________________

DOB: _________ SS#: _______________ Ins. ID#___________________

Medical Information

Physician's Name: ____

Allergies to medications? __Yes __No

If yes, please list: ____

Other Allergies: ____

Are you currently taking any medications? __Yes __No

List Current Medications/reason for taking: ________________________

____

____

____

Date of last physical exam? _______________________________________

Other Medical Conditions: ____

____

MEDICAL HISTORY

- __Yes __No Heart Disease
- __Yes __No Heart Defect
- __Yes __No Heart Murmur
- __Yes __No Heart Surgery
- __Yes __No Pacemaker
- __Yes __No Stroke
- __Yes __No High Blood Pressure
- __Yes __No Artificial Joints
- __Yes __No PreMed for Dental Care
- __Yes __No Diabetes
- __Yes __No Cancer/Tumor
- __Yes __No Radiation
- __Yes __No Chemo
- __Yes __No Epilepsy
- __Yes __No Anemia
- __Yes __No Prolonged bleeding
- __Yes __No Tuberculosis
- __Yes __No Lung Disease
- __Yes __No Asthma
- __Yes __No Inhaler use
- __Yes __No Sinus Infections
- __Yes __No Acid reflux
- __Yes __No Liver Disease
- __Yes __No Jaundice
- __Yes __No Arthritis
- __Yes __No Glaucoma
- __Yes __No Venereal Disease/STD
- __Yes __No HIV+
- __Yes __No Smoker/Vaper
- __Yes __No Marijuana use
- __Yes __No Illicit drug use
- __Yes __No Oral Contraceptives
- __Yes __No Pregnant--DueDate:______
- __Yes __No Surgery:

____

I am financially responsible for my own account. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. If insurance coverage exists, I authorize payment to go directly to my dentist.

____ ______________________________
Signature Date