6120 Brandon Ave, Suite 214, Springfield, VA 22150
703-451-3303
contact@gracefulsmiles.net
www.gracefulsmiles.dentist

New Patient Form

Today's Date_____

Patient Name: First _____ MI____ Last_____ Preferred Name: _____

Gender: ❑ M ❑ F SSN: _____ Birth Date (mm/dd/yyyy): _____

Address: Street_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Mobile_____ Text Msg, OK? ❑ Y ❑ N
Email address_____

Spouse, partner, or parent name? _____
Is it okay if we share treatment related information with someone? ❑Yes ❑No
If yes, specify name _____ relationship: _____

Person to contact in case of emergency? _____ Phone: _____
Relationship: _____

Pharmacy information
Name of Pharmacy: _____ Phone: _____
Address _____

Dental History

Date of last dental care visit: _____, Date of last dental x-rays: _____
Have you ever had orthodontic (braces) treatment? □ Yes □ No
Have you ever had periodontal (gum) treatments? □ Yes □ No
Do you grind your teeth? □ Yes □ No,

Do you have any of the following?

□ Bad Breath	□ Dry Mouth	□ Partials
□ Bleeding Gums	□ Difficulty Chewing	□ Sensitivity to Cold
□ Blisters on Mouth	□ Ear Pain	□ Sensitivity to Heat
□ Broken Fillings	□ Jaw Pain	□ Sensitivity to Sweets
□ Clicking Jaw	□ Loose Teeth	□ Sensitivity to Pressure
□ Dentures	□ Mouth Pain	□ Swollen Gums
□ Mouth Sores	□ Difficulty Opening and Closing	

How often do you brush? # times/ day _____, How often do you floss? # times/ day _____

Medical History:

Your Physician: _____
Have you ever had any serious illness or operation? □ Yes □ No
If yes, describe? _____

Have you ever smoked? □ Yes □ No
Of Years _____ # of Packs/ day _____
Do you smoke now? □ Yes □ No
Of Years _____ # of Packs/ day _____
Do you use recreational drugs? □ Yes □ No
Types? _____
times/ week _____
How much caffeine do you drink per day?
drinks/ day _____

Women: are you pregnant? □ Yes □ No Are you breastfeeding? □ Yes □ No
If yes, when is your due/delivery date? _____

Check if you have any of the following:

☐ Alcoholism	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Cholesterol	☐ Migraines	☐ Stomach Ulcer
☐ Allergies	☐ Blood Disease	☐ Epilepsy	☐ Joint Disorder	☐ Osteoporosis	☐ Substance Abuse
☐ Anemia	☐ Blood Transfusion	☐ Hay Fever	☐ Kidney Disorder	☐ Pacemaker	☐ Thyroid Disorder
☐ Anxiety Disorder	☐ Bowel Disorder	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Tuberculosis
☐ Arthritis	☐ Cancer	☐ Heart Problems	☐ Lung Disorder	☐ Sinus Problems	☐ Venereal Disease
☐ Asthma	☐ Diabetes	☐ Hepatitis- A, B or C	☐ Lupus	☐ Skin Disorder	☐ Major Surgery
☐ AIDS / HIV	☐ Depression	☐ High Blood Pressure	☐ Measles	☐ Stroke	☐ Joint Replacement

List of medications you are currently taking and the correlating diagnosis:

Medication	**Diagnosis**

List of any allergies you may have:

Allergy	**Allergy**

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Cancellations, Missed, and/or Late Appointments

At Graceful Smiles Dentistry, your appointment time is reserved specifically for you. This personalized approach allows us to provide the highest quality of care and maintain a seamless experience for all our patients. However, missed appointments or late cancellations disrupt our schedule and impact other patients who may need care.

To ensure fairness and efficiency, we kindly request at least 24 hours' advance notice if you need to cancel or reschedule your appointment. This allows us the opportunity to offer your time slot to another patient in need. Appointments canceled with less than 24 hours' notice or missed entirely will incur a $50 cancellation fee. Repeated missed appointments or late cancellations may also result in additional charges or, in certain cases, dismissal from the practice.

Appointment Confirmations

To help us maintain an efficient schedule, we require that all appointments be confirmed at least 24 hours before the scheduled time. If we do not receive confirmation, we may cancel the appointment and offer the time slot to another patient. Our team will make every effort to remind you via phone, text, or email, so please ensure your contact information is up to date.

Late Arrivals

If you anticipate being late for your appointment, please notify us as soon as possible by calling 703-451-3303. Patients arriving more than 15 minutes late may experience a reduced appointment time to accommodate other scheduled patients. In some cases, arriving late may require rescheduling your appointment to another day.

New Patients

For new patients, we kindly request that you arrive 10 minutes before your scheduled appointment. Additionally, please complete the New Patient Form online ahead of time to help streamline the check-in process. If you prefer to fill out the paperwork at the office, please note that it may shorten the time available for your planned procedures if it overlaps with your appointment.

Our Commitment to You

We value your time and strive to provide the best care possible in a timely manner. By adhering to these policies, you help us maintain a schedule that benefits all our patients.

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Payment Policy

At Graceful Smiles Dentistry, we are committed to providing the highest quality of care while being transparent about financial responsibilities. To maintain clarity and fairness, we have established the following payment policy:

Co-Payments and Balances Due

All co-payments, as determined by your insurance plan, are due at the time of service. Co-payments cannot be waived as they are a contractual obligation between you and your insurance provider.

Any remaining balance not covered by insurance, including deductibles, coinsurance, or services deemed non-covered or out-of-network, is the responsibility of the patient. These balances must be paid in full on the day of your appointment.

Insurance Estimates

As a courtesy, our team will provide an estimate of your out-of-pocket costs based on the information provided by your insurance company. Please note that these are estimates only. Your final financial responsibility may vary based on your insurance company's processing of the claim.

Methods of Payment

For your convenience, we accept a variety of payment options, including:

- Cash
- Major credit cards (Visa, MasterCard, Discover, American Express)
- Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA)
- In-house discount plan (if applicable)

Additional Information

If you have any questions about your insurance benefits, coverage, or payment responsibilities, our team is happy to assist you. However, understanding your plan and its limitations is ultimately your responsibility.

By signing below, I acknowledge receipt of Graceful Smiles Dentistry's Cancellation and Payment Policies.

_____ _____

Print name Date

_____ _____

Patient or legally authorized individual signature Relationship to patient

Graceful Smiles Dentistry

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Graceful Smiles Dentistry ("Dental Practice"). "We" and "our" mean the Dental Practice. "You" and "your" mean our patient.

II. How to Contact Us / Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Graceful Smiles Dentistry's Privacy Official at:

Dr. Jenny Lu, DDS
Dr. Sang-jin Nam, DDS
Dr. Aileen Kim, DDS
Dr. Oliver Chu, DMD
6120 Brandon Ave., Suite 214
Springfield, VA 22150
Phone: 703-451-3303
Email: Contact@gracefulsmiles.net

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal, and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other purposes permitted or required by law.

Protected health information includes information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services.

We are required by law to:
Maintain the privacy of your protected health information;
Provide you with this Notice of our legal duties and privacy practices regarding your protected health information; and
Comply with the terms of the Notice currently in effect.

IV. Last Revision Date

This Notice was last revised on **February 1, 2026**.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. **Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
2. **Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
3. **Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
4. **Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text, or email.
5. **Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
6. **Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.
7. **Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, “business associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. **Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.
2. **Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include preventing or controlling disease, injury or

disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. **Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.
4. **Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.
5. **Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.
6. **Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.
7. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner, or funeral director to allow them to carry out their duties.
8. **Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.
9. **Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.
10. **Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.
11. **Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.
12. **Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law.

You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization.

If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

February 2026 Update: Certain information may be subject to additional federal confidentiality protections, including records related to substance use disorder treatment, when applicable. If these protections apply, they may limit how such information may be used or disclosed, and may include restrictions on re-disclosure.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review your health information, including receiving copies in electronic format when applicable. If we maintain your records electronically, you have the right to request these records in a readily producible electronic format or direct us to send them to a designated third party electronically. Reasonable, cost-based fees may apply for providing access or copies.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable, and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information:
(1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach;
(2) the steps you should take to protect yourself from potential harm resulting from the breach; and
(3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for Sensitive Health Information

Certain federal and state laws require heightened privacy protections for sensitive information, such as HIV-related information, alcohol and substance use disorder information, mental health records, and genetic information. For example, the Genetic Information Nondiscrimination Act prohibits using genetic information for insurance underwriting purposes.

February 2026 Update: Certain information may be protected by additional federal confidentiality requirements, including records related to substance use disorder treatment, when applicable. When these protections apply, they may include restrictions on use and disclosure and restrictions on re-disclosure.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to modify this Notice to align with evolving laws or privacy practices. Updates will be posted in our office, on our website (if applicable), and will be made available upon request.

X. How to Make Privacy Complaints

If you believe your privacy rights have been violated or have concerns regarding the use or disclosure of your information, you may contact our Privacy Official listed in Section II of this Notice.

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You may file a complaint in writing or electronically. We are committed to protecting your rights and will not retaliate against you for filing a complaint.

U.S. Department of Health and Human Services
Office for Civil Rights (OCR)
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

OCR Complaint Portal (online): https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
OCR Complaint Form Information: https://www.hhs.gov/ocr/complaints
Phone: 1-800-368-1019
TDD: 1-800-537-7697

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

[Please Print Name]

_____

[Signature]

_____

[Date]

For Office Use Only

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

- □ The individual refused to sign.
- □ Communications barriers prohibited obtaining the acknowledgement.
- □ An emergency prevented us from obtaining acknowledgement.
- □ Other (Please Specify)