# Welcome

CONFIDENTIAL

## PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Bad breath | ☐ Yes | ☐ No | Burning sensation on tongue | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No | Chew on one side of mouth | ☐ Yes | ☐ No | Mouth pain, brushing | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes | ☐ No |
| | | | Clicking or popping jaw | ☐ Yes | ☐ No | Pain around ear | ☐ Yes | ☐ No |
| | | | Dry mouth | ☐ Yes | ☐ No | Periodontal treatment | ☐ Yes | ☐ No |
| | | | Fingernail biting | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes | ☐ No |
| | | | Food collection between the teeth | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes | ☐ No |
| | | | Foreign objects | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes | ☐ No |
| | | | Grinding teeth | ☐ Yes | ☐ No | Sensitivity when biting | ☐ Yes | ☐ No |
| | | | Gums swollen or tender | ☐ Yes | ☐ No | Sores or growths in your mouth | ☐ Yes | ☐ No |
| | | | Jaw pain or tiredness | ☐ Yes | ☐ No | How often do you floss? _____ | | |
| | | | Lip or cheek biting | ☐ Yes | ☐ No | | | |
| | | | Loose teeth or broken fillings | ☐ Yes | ☐ No | How often do you brush? _____ | | |

## HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| | | High Blood Pressure | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Tumor or growth on head or neck | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | | |
| Cortisone Treatments | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Emphysema | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No | | |

Do you wear contact lenses? ☐ Yes ☐ No

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## MEDICATIONS

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

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

## PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____

## UPDATE (To be filled in at future appointment)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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# DENTAL MATERIAL FACT SHEET INSTRUCTIONS

On May 14, 2004 the Dental Board of California updated the Dental Material Fact Sheet Business & Professions Code Section 1648.15 to require the following:

- The dentist must provide the updated fact sheet to every new patient and to patients' of record before performing dental restoration work. The dentist needs to provide the fact sheet to each patient only once.
- The patient must sign an acknowledgement of receipt of the fact sheet and a copy of the acknowledgment must be placed in the patients' dental record.
- If the Board updates the fact sheet, the updated fact sheet must be given to patients' in the same way.
- The dentist must also provide the fact sheet to any patient upon **REQUEST.**

The requirement shall not apply to any surgical, endodontic, periodontics, or orthodontic dental procedure in which dental restorative materials are not used.

_____ _____

Signature of Patient/Guardian Date

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# POLICY REGARDING INSURANCE ASSIGNMENT

Our office is please to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. Following is a statement of our policies governing insurance claims

- Although our office does bill the insurance company, it is necessary for the patient to have all of the insurance information forms filled out completely. If this is not completed, we will not be able to appropriately bill the insurance company, and the responsibility for payment then becomes that of the patient. We are sorry, but there are no exceptions to this policy.

- The patient will pay the co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation.

- Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patients' insurance company has not made a payment to our office within 90 days, we may request the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.

- Our office does NOT guarantee that the patients' insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patients' insurance claim is denied, the patient is then considered to be responsible for the full amount.

- Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions which might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES, PLEASE SIGN AND DATE BELOW:

_____ _____

Signature of Patient/Guardian Date

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## 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.

We respect our legal obligation to keep health information that identifies you private we are obligated by law to give you notice of our privacy practices This Notice describes how we protect your health information and what rights you have regarding it.

### *TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:*

The most common reason why we use or disclose your health information is for treatment, payment or health care operations Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney) "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission If we need to disclose your health information outside of our office for these reasons, We will ask you for special written permission.

### *USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:*

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

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- Uses and disclosures for health oversight activities, such as for the licensing of doctors, for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

***APPOINTMENT REMINDERS:***

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment we may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

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***OTHER USES AND DISCLOSURES:***

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

***YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:***

The law gives you many rights regarding your health information, you can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will

send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment oi health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.

***OUR NOTICE OF PRIVACY PRACTICES:***

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already frgve as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

***COMPLAINTS:***

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this notice if you prefer, you can discuss your complaint in person or by phone.

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***ACKNOWLEDGEMENT OF RECEIPT:***

I acknowledge that I reviewed a copy of Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian Date