Patient Information Form

Patient Information Form

Today's Date

Patient First Name | **Patient Middle Initial** | **Patient Last Name** | **Nickname**

Home Phone | **Work Phone** | **Mobile Phone** | **Email Address**

Address | **City** | **State** | **Zip**

What is your preferred method of contact?

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

Social Security No. | **Date of Birth**

Gender

☐ Male ☐ Female ☐ Other

Martial Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Preferred Pronouns

Name of emergency contact

Is the patient a minor?

☐ Yes ☐ No

Name of Responsible Party

Relationship to Patient

☐ Self ☐ Spouse ☐ Parent ☐ Other

If other, please specify

Date of Birth

If patient is a minor, primary residency

☐ Both parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address (if different from patient) | **City** | **State** | **Zip**

Cell Phone

Dental Benefit Plan Information

Do you have a primary dental insurance?

☐ Yes ☐ No

Primary Dental Plan Name **Phone**

Address **City** **State** **Zip**

Name of Insured **Date of Birth**

Group # **Policy Number**

Patient Relationship to Insured **Upload Dental Insurance Card**

Do you have a secondary dental insurance?

☐ Yes ☐ No

Secondary Dental Plan Name **Phone**

Address **City** **State** **Zip**

Name of Insured **Date of Birth**

Group # **Policy Number**

Patient Relationship to Insured **Upload Secondary Dental Insurance Card**

Health History Form

Confidential Health History Form

Today's Date

Patient First Name | **Patient Middle Initial** | **Patient Last Name** | **Date of Birth**

I. Choose appropriate answer.

1. Is your general health good?

☐ Yes ☐ No

If NO, explain.

2. Has there been a change in your health within the last year?

☐ Yes ☐ No

If YES, explain.

3. Are you being treated by a physician now?

☐ Yes ☐ No

If YES, explain.

4. Have you had problems with prior dental treatment?

☐ Yes ☐ No

If YES, explain.

Date of last medical exam | **Reason for exam**

Date of last medical exam | **Name of last treating dentist**

5. Are you in pain now?

☐ Yes ☐ No

If YES, explain.

6. Are your teeth sensitive to hot or cold?

☐ Yes ☐ No

If YES, explain.

7. Do you have any fear of dental work?

☐ Yes ☐ No

If YES, explain.

8. Do your gums bleed when you brush?

☐ Yes ☐ No

If YES, explain.

9. Do you require pre-medication for your dental visits?

☐ Yes ☐ No

If YES, explain.

Previous Dentist Name | **Previous Dentist Phone Number** | **Previous Dentist City**

What are your main dental conerns?

II. Have you had or do you have any of the following? *(Please select Yes or No for each)*

Epstein Barr Virus
☐ Yes ☐ No

Heart attack
☐ Yes ☐ No

Artificial joint
☐ Yes ☐ No

Heart disease
☐ Yes ☐ No

Stomach problems or ulcers
☐ Yes ☐ No

Heart defects
☐ Yes ☐ No

Heart murmur
☐ Yes ☐ No

Rheumatic fever
☐ Yes ☐ No

High blood pressure
☐ Yes ☐ No

Seizures
☐ Yes ☐ No

Recent Surgeries
☐ Yes ☐ No

Hospitalization
☐ Yes ☐ No

Diabetes
☐ Yes ☐ No

Mitral Valve Prolapse
☐ Yes ☐ No

Chemotherapy
☐ Yes ☐ No

Cancer
☐ Yes ☐ No

Radiation
☐ Yes ☐ No

Arthritis, rheumatism
☐ Yes ☐ No

Emphysema or other lung disease
☐ Yes ☐ No

Kidney or bladder disease
☐ Yes ☐ No

Stroke
☐ Yes ☐ No

Eating disorders
☐ Yes ☐ No

Osteoporosis
☐ Yes ☐ No

Thyroid disease
☐ Yes ☐ No

Hepatitis
☐ Yes ☐ No

Drug Addiction
☐ Yes ☐ No

Asthma
☐ Yes ☐ No

Herpes
☐ Yes ☐ No

Canker or cold sores
☐ Yes ☐ No

Anemia
☐ Yes ☐ No

Liver disease
☐ Yes ☐ No

Blood Transfusion
☐ Yes ☐ No

TMJ Dysfunction
☐ Yes ☐ No

Latex Allergy
☐ Yes ☐ No

Tuberculosis
☐ Yes ☐ No

Pacemaker
☐ Yes ☐ No

This information will not be released unless specifically authorized by patient.

AIDS/HIV
☐ Yes ☐ No

Anxiety
☐ Yes ☐ No

Depression
☐ Yes ☐ No

Treatment for emotional condition
☐ Yes ☐ No

lll. Please list allergies to any medications or materials (If none please enter N/A)

IV. Are you taking or have you taken any of the following in the last three months? *(Please choose Yes or No for each)*

Cortico - Steroids
☐ Yes ☐ No

Over the counter medicines
☐ Yes ☐ No

Antibiotics
☐ Yes ☐ No

Supplements
☐ Yes ☐ No

Aspirin
☐ Yes ☐ No

V. Please list all medications you are currently taking:

VI. Women Only *(Please choose Yes or No for each)*

Are you or could you be pregnant?

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

Are you taking birth control pills?

☐ Yes ☐ No

If YES, what month?

VII. All patients *(Please choose Yes or No for each)*

Do you have or have you had any other diseases or medical problems NOT listed on this form?

☐ Yes ☐ No

If YES, explain.

Is there any issue or condition that you would like to discuss with the dentist in private?

☐ Yes ☐ No

Have you ever been pre-medicated for dental treatment?

☐ Yes ☐ No

If YES, why?

CONSENT:

1. I hereby authorize the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.
4. I understand that it is my responsibility to advice your office of any changes in the information obtained on this form.
5. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Responsible Party Signature

Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 02/14/2003 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

How we may use and disclose health information about you

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example. we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect yo your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities including disclosures to:

• Prevent or control disease, injury and disability;

• Report child abuse or neglect.

• Report reactions to medications or problems with products or devices;

• Notify a person of a recall or replacement of products or devices:

• Notify a person who may have been exposed to a disease or condition, or

• Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution of law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U. S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already, taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than one in a 12-month period, we may charge you a reasonable e, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of you PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handed under the alternative means or location you request. We will accommodate at reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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 you request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 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.

Privacy Official Name and Contact Information

Dr. George N. Little

PO Box 975

Ross, CA 94957

(415) 925-2545

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

Acknowledgement Receipt

George N. Little, DDS

Acknowledgment of Receipt of Notice of Privacy Practices

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

Name

Signature

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:

- Individual refused to sign document
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

☐ **Individual refused to sign document**

☐ **Communication barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**

☐ **Other**

If other, please specify

Financial Practices

ROSS FAMILY DENTISTRY FINANCIAL PRACTICES

Payment of Your Bill

Payment of your bill is due at the time of your treatment. We will submit your insurance claim to your carrier, who will then reimburse payment directly to you. Please know that insurance payments can take up to 4 to 8 weeks, sometimes longer for reimbursement. You may pay by check, cash, Visa, Mastercard or American Express.

Financial Arrangements

Our financial manager will work with you to arrange a reasonable financial payment plan if you have financial difficulty. Any unsettled account balances not payable within a reasonable duration, will be assigned to a collection agency. **This is a practice we do NOT wish to observe.** If your account is assigned to a collection agency; a 40% agency fee will be added to your balance.

Missed Appointments

Appointment times are reserved especially for you. If you are unable to keep an appointment there will be no charge provided you give us **48-hour** notice. Late cancellations or no-shows may be billed a $75 fee.

Special Arrangements

For extensive treatments, payment plans may be arranged with our Financial Manager before treatment is initiated. Full payment must be made prior to the completion of treatment for crowns and other major work.

Patient Financial Agreement

I agree that I am fully responsible for the total payment of all procedures performed in this office. This includes any treatment that is not a benefit of dental insurance I may have.

Unless special arrangements have been made in advance of treatment, I understand that all services are due to be paid in full within 60 days of the date of service, regardless of whether my insurance benefits have been received by this office.

I acknowledge that I have read, understand and agree to the above practices.

Name

Email Address

Signature of Responsible Party