Welcome to our Practice

PATIENT INFORMATION...

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not ..... Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Other _____
❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue / lips
❑ Toothache
❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam _____ Last dental x–rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) ☐☐☐☐☐☐☐☐☐☐

Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Are you immunosuppressed *(possibly from transplant surg.)*	❑	❑	Bleeding tendency	❑	❑	Kidney trouble
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Problems w/ immune system *(possibly from med. / surg.)*	❑	❑	Are you on dialysis
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Jaundice / Liver disease	❑	❑	Arthritis / Joint disease
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Prosthetic joint / Implant
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Infectious mononucleosis	❑	❑	Osteoporosis / Osteopenia
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Osteonecrosis
❑	❑	Heart attack(s)	❑	❑	Do you smoke *if so, # packs a day*_____	❑	❑	Fainting spells	❑	❑	Stomach ulcers
❑	❑	Irregular heart beat				❑	❑	Convulsions / Epilepsy	❑	❑	Contagious diseases
❑	❑	Cardiac pacemaker	❑	❑	Do you use chewing tobacco	❑	❑	Stroke	❑	❑	Delay in healing
❑	❑	Heart surgery	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Anemia
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / Night sweat	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Are you on a diet
❑	❑	Mental health problems	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles	❑	❑	Contact lenses
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Low blood sugar			
❑	❑	Asthma									

MEDICATION & ALLERGIES...

Are you now taking, or have you ever taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Coumadin, Aspirin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION			DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	I have no known allergies.

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Covina Family Dental is required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information We maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices and terms of this notice. If We make a material change to Our privacy practices, We will provide a revised notice by direct mail to you reflecting that change within 60 days of the change and We will otherwise post that revised noticed on Our website www.CovinaFamilyDental.com. We reserve the right to make any revised or changed notice effective for information We already have and for information that We receive in the future.

**For purposes of this Notice of Privacy Practices, "We", "US" & "Our" refer to the health plans that are affiliated with Covina Family Dental.*

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights and described in this notice
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate Our business. For example, We may use or disclose your health information:

- **For Payment** of premiums due Us, to determine your coverage, and process claims for health care services you receive, including for subrogation or coordination of other *Benefits* you may have. For example, We may tell a doctor whether you are eligible for coverage and what percentage of the bill nay be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your Physicians,

hospitals, specialists, and other dentists to help them improve medical and dental care to you.

- **For Health Care.** We may use or disclose health information as necessary to operate and manage Our business activates related to providing and managing your health care coverage. For example, We might talk to your Physician, other specialist, and other dentist to suggest a treatment plane or wellness program that could help improve your health or We may analyze data to determine how We can improve Our services.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed bylaw as of February 17, 2010
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health Plan, We may share summary health information and enrollment and disenrollment information with the Plan sponsor. In addition, We may share other health information with the Plan sponsor for Plan administration if the Plan sponsor aggress to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Reminders.** We may use or disclose health information to send you reminders about your Benefits or care, such as appointment reminders for all dental appointments and for new letters or any other email or text communications.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as family members, when you are incapacitated or in an Emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, We will use Our best judgment to decide if the disclosure is in your best interest.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an Emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatment or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may disclose information to funeral directors as necessary to carry out their duties.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security or the correctional institution.
- **To Business Associates** that perform functions on Our Behalf or provide Us with services if the

information is necessary for such functions or services. Our business associates are required, 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. As of February 17, 2010, Our business associates also will be directly subject to federal privacy laws.

- **For Data Breach Notification Purposes.** We may use your contact information to provide legally- required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your Plan through with you receive coverage.

Except for uses and disclosures described and limited as set forth in this notice, We will use and disclose your health information only with a written authorization form you. Once you give Us authorization to release your health information, We cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if We have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed here (626) 331-0688.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

- **You have the right to ask to restrict use** or disclose of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on Dependent access that authorize your dependents to request certain restrictions. **Please note that while We will try to honor your request and will permit request consistent with Our policies, We are not required to agree to any restriction.**
- **You have the right to request** that a provider not send health information to Us in certain circumstances it the health information concerns a health care item or services for which you have paid the provider out of pocket in full.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable request where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal request to receive confidential communications, but request to modify or cancel a previous confidential communication request must be made in writhing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claim and case or medical / dental management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, We may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If We deny your request, you have the to have the denial reviewed. If We maintain an electronic health record containing your health information, you have the right to request that We send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information We maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested Amendment. Mail your request to the address listed below. If We deny your request, you may have a statement of you disagreement added to your health information.
- **You have the right receive an accounting** of certain disclosures of your information made by Us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to January 2000; (ii) for treatment, payment, and health care

operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which Federal law does not require Us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a coy of this notice ay any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

EXERCISING YOUR RIGHTS

- **Contacting Covina Family Dental.** If you have any questions about this notice or want to exercise any of your rights, please call us at (626) 331-0688.
- **Submitting a Written Request.** Mail to Us your written request for modifying or cancelling a confidential communication, for copies of your records, or for Amendments to your record, at the following Address

Covina Family Dental
166 West College Street, Suite C
Covina, CA 91723

- **Filling a Complaint.** If you believe your privacy rights have been violated, you may file a complaint to Us at the address listed above.
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filling a complaint.

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **HIPAA NOTICE OF PRIVACY PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

SIGNATURE: _____

PRINTED NAME: _____ DATE:_____

Relationship to Patient (If not self) _____

Appointment Cancellation Policy

We here at Covina Family Dental value your time. We will confirm your appointment via email, text, and/or phone call. If you would like to opt out of any of these methods, please let us know and we will be happy to make that change for you.

If you need to reschedule or cancel your appointment, please call us at least 48 hours before your appointment. This will allow us time to offer that appointment to another patient.

We understand that unpredictable emergencies can arise. For that reason we do allow one last minute cancellation per calendar year. **If there is a second instance that you miss an appointment or cancel within 24 hours of your appointment, there will be a charge of $50 to your account.**

Please feel free to ask any one of the Covina Family Dental team members if you have any questions or concerns about this policy.

I have read and understand the cancellation policy for Covina Family Dental.

Signature_____

Date_____