SC DENTAL PATIENT INFORMATION

Email | Today's Date

Welcome! Thank you for selecting SC Dental Care. This information is necessary for our files and will be considered CONFIDENTIAL. As required by law, SC Dental Care adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital and allows us to provide appropriate care for you. SC Dental Care does not use this information to discriminate.

Name: Last / First / Middle | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information
For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information
For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Medical Information For the following questions, please mark (X) your responses to the following questions.

(Check DK if you Don't Know the answer to the question)

Question	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ________ If yes, have you had any complications? ________			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ________			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, ...)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ________			
If yes, how much do you typically drink in a week? ________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ________	☐	☐	☐
Aspirin ________	☐	☐	☐
Penicillin or other antibiotics ________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ________	☐	☐	☐
Sulfa drugs ________	☐	☐	☐
Codeine or other narcotics ________	☐	☐	☐
Metals ________	☐	☐	☐
Latex (rubber) ________	☐	☐	☐
Iodine ________	☐	☐	☐
Hay fever/seasonal ________	☐	☐	☐
Animals ________	☐	☐	☐
Food ________	☐	☐	☐
Other ________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ________ ☐ ADHD/ADD ☐ Autism/ASD			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ________			
Recurrent Infections	☐	☐	☐
Type of infection: ________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

Question	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

MUST BE COMPLETED

Reviewed by Doctor

X________

Review Date________

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Print Name________ Signature of Patient or Guardian________ Date________

OFFICE USE ONLY - HEALTH QUESTIONNAIRE MUST BE UPDATED EVERY YEAR

Year 2 - Changes in Health ________
Date________ Signature________
Reviewed by: ________

Year 3 - Changes in Health ________
Date________ Signature________
Reviewed by: ________

Year 4 - Changes in Health ________
Date________ Signature________
Reviewed by: ________

Year 5 - Changes in Health ________
Date________ Signature________
Reviewed by: ________

Consent to Release Medical Information to Family Members and/or Associates

I, ______________________________ authorize the release of medical information pertaining

to my condition and/or treatment, appointments and balance fees at SC Dental Care to:

(Name of Relative/Associate) ______________________________

(Relationship to you) ______________________________

Signature ______________________________ Date of Birth ______________

Print Patient Name ______________________________ Today's Date ______________

22972 Moulton Parkway, Suite 106, Laguna Hills, CA 92653
(949) 770-3010 • Fax: (949) 837-5410

Insurance and Financial Policy

At **SC Dental Care**, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients; some have benefits, while others do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

Your dental benefits are based upon a contract made between your employer and an insurance company. ***If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.*** Dental benefit plans will never pay for completion of dental care. It is only meant to assist you.

We currently accept all private care insurance plans and most managed care plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We **estimate** your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your **exact** insurance benefit we will be happy to file a Pre-treatment Authorization with your insurance company prior to treatment. This does delay treatment, but will give you the exact out-of pocket figures you may require.

We bill your insurance as a **courtesy**. If your insurance does not pay **within 90 days.**

*** SC DENTAL CARE** reserves the right to request payment in full for services from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract. **Ultimately, you are responsible for all charges incurred in our office.**

*** SC DENTAL CARE** does require payment in full for your portion **at the time of service**. We accept MasterCard, Visa, American Express, Discover, Cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit who offers a 12-month same as cash or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of our patient service staff for an application.

We welcome you to our family and look forward to helping you get healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more pleasant, please do not hesitate to ask one of our staff members.

Print Name ____

Signature ___________________________________ Date:__________

22972 Moulton Parkway, Suite 106, Laguna Hills, CA 92653
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Excellence In Dentistry

• • • • •

GENERAL DENTISTRY

• • • • •

COSMETIC DENTISTRY

• • • • •

INVISALIGN

• • • • •

Rodney W. Boyd, D.D.S.
Tabby Abulhosseini, D.D.S.
Paul R. Murray, D.M.D.

Dental Appointment Policy

Your dental appointment time is reserved specifically for you. We strongly encourage all patients to keep their appointments; however we understand situations may arise that create changes in the patient's schedule

Please note that if you must change your appointment, SC Dental Care requires a 24-hour notice in order to avoid a cancelation fee of $65.00 or the contracted insurance fee.

The cancelation fee covers the cost of materials ordered and prepared specifically for your dental appointment.

Print Name____

Signature ______________________________

Date:___________

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

22972 Moulton Parkway, Suite 106, Laguna Hills, CA 92653 • (949) 770-3010 • Fax: (949) 837-5410

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgment. (Please Print)

PATIENT'S LAST NAME ______________________________

FIRST NAME ______________________________

SC Dental Hipaa Notice of Privacy Practices

This notice describes how protected health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your protected health information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We ust follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until replaced. You may request a copy of out Notice at any time. For more information about our privacy practics, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose protected health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your protected health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use or disclose your protected health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: Our dental facility employs an open system of delivering dental care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to accommodate you. We may use or disclose, as needed, your protected health information in order to support our business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in. We may call you by name in the reception room when the doctor is ready to see you, and he may have a copy of that day's schedule with your name on it in his operatory. We may use or disclose your protected health information, as needed to contact you by phone, e-mail, or mail, to confirm your dental appointment. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information. We may use or disclose your protected health information, as necessary, to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

YOUR AUTHORIZATION: We will obtain your written authorization should we need to use or disclose your protected health information outside of our third party associates.

TO YOUR FAMILY AND FRIENDS: We must disclose your protected health information to you, as described in the Patient Rights section of this Notice. We may disclose your protected health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN YOUR CARE: We may use or disclose your protected health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or your death. If you are present, prior to use or disclosure of your protected health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your protected health information based on a determination using our professional judgement, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms or your protected health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your protected health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your protected health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your protected health information to appropriate authorities if we reasonably believe your protected health information to the extent necessary to avert a serious threat to our health or safety, or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities, the protected health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials protected health information required by lawful intelligence, counterintelligence, and othe national security activities. We may disclose protected health information or an inmate or patient under certain circumstances.

PATIENT RIGHTS:

ACCESS: You have the right to look at or obtain copies of your protected health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make your request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based free for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 without x-rays, and $20.00 if x-rays are requested. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your protected health information for purposes other than: treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not prior to April 14, 2003. If you request this additional restrictions, however, if we do, we will abide by our agreement (except in an emergency).

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, however, if we do, we will abide by our agreement (except in any emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your protected health information. Your request must be in writing, and must explain why the Information should be amended. We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our website, or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 you disagree with a decision we made about access to your protected health information, or in response to a request you made to amend or restrict the use or disclosure of your protected 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 may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Privacy Contact: Debbie Canu

Phone: (949) 496-7910

For Office Use Only Below This Line

Please specify the reason the patient chose not to sign the acknowledgment of receipt of the HIPAA Notice of Privacy Practices.

- ☐ Patient / Parent or Legal Representative received the HIPAA Notice of Privacy Practices but refused to sign the acknowledgment of Receipt.
- ☐ Patient/Parent or Legal Representative unavailable to acknowledge receipt of the HIPAA Notice of Privacy Practices.

Staff Signature: ______________________ Date: ____________

If you would like a copy of this notice for your records, please inform our staff.

Rev. 3/13

______________________ Date ________ ______________________ Date ________

Patient/Parent's Signature: Patient Representative's Signature: