Patient Information Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a Minor? ☐ Yes ☐ No Full-time Student ☐ Yes ☐ No Name of School _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)* _____

☐ Advertisement _____ ☐ Local Dental Society _____

☐ Our Web site ☐ Other _____

Please list other members of your immediate family who are patients in our practice

_____ _____ _____ _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, checks, or credit cards
* *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $ 75.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $ 50.00 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____ (initial)

I hereby acknowledge that a copy of this practice'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. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI ____ Last _____ Date of Birth _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No Is your general health good?
   If NO, explain _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes / No Are you being treated by a physician now?
   If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes / No Are you in pain now?
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

- ☐Yes / No☐Chest pain (angina)
- ☐Yes / No☐Fainting spells
- ☐Yes / No☐Recent significant weight loss
- ☐Yes / No☐Fever
- ☐Yes / No☐Night sweats
- ☐Yes / No☐Persistent cough
- ☐Yes / No☐Coughing up blood
- ☐Yes / No☐Bleeding problems
- ☐Yes / No☐Blood in urine
- ☐Yes / No☐Blood in stools
- ☐Yes / No☐Diarrhea or constipation
- ☐Yes / No☐Frequent urination
- ☐Yes / No☐Difficulty urinating
- ☐Yes / No☐Ringing in ears
- ☐Yes / No☐Headaches
- ☐Yes / No☐Dizziness
- ☐Yes / No☐Blurred vision
- ☐Yes / No☐Bruise easily
- ☐Yes / No☐Frequent vomiting
- ☐Yes / No☐Jaundice
- ☐Yes / No ☐Dry mouth
- ☐Yes / No ☐Excessive thirst
- ☐Yes / No☐Difficulty swallowing
- ☐Yes / No☐Swollen ankles
- ☐Yes / No☐Joint pain or stiffness
- ☐Yes / No☐Shortness of breath
- ☐Yes / No☐Sinus problems

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

- ☐Yes / No☐Heart disease
- ☐Yes / No☐Family history of heart disease
- ☐Yes / No☐Heart attack
- ☐Yes / No☐Artificial joint
- ☐Yes / No☐Stomach problems or ulcers
- ☐Yes / No☐Heart defects
- ☐Yes / No☐Heart murmurs
- ☐Yes / No☐Rheumatic fever
- ☐Yes / No☐Skin disease
- ☐Yes / No☐Hardening of arteries
- ☐Yes / No☐High blood pressure
- ☐Yes / No☐Seizures
- ☐Yes / No☐Cosmetic surgery
- ☐Yes / No☐Surgeries
- ☐Yes / No☐Hospitalization
- ☐Yes / No☐Diabetes
- ☐Yes / No☐Family history of diabetes
- ☐Yes / No☐Tumors or cancer
- ☐Yes / No☐Chemotherapy
- ☐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☐Asthma
- ☐Yes / No☐Hepatitis
- ☐Yes / No☐Sexual transmitted disease
- ☐Yes / No☐Herpes
- ☐Yes / No☐Canker or cold sores
- ☐Yes / No☐Anemia
- ☐Yes / No☐Liver disease
- ☐Yes / No☐Eye disease
- ☐Yes / No☐Transplants
- ☐Yes / No☐Tuberculosis

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

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

- ☐Yes / No☐Aspirin
- ☐Yes / No☐Darvon
- ☐Yes / No☐Codeine
- ☐Yes / No☐Latex
- ☐Yes / No☐Local anesthetic (Novocain or Xylocaine)
- ☐Yes / No☐Valium
- ☐Yes / No☐Demerol
- ☐Yes / No☐Penicillin
- ☐Yes / No☐Food
- ☐Yes / No☐Erythromycin
- ☐Yes / No☐Tetracycline
- ☐Yes / No☐Vicodin
- ☐Yes / No☐Percodan
- ☐Yes / No☐Nitrous oxide
- ☐Yes / No☐Metal

Others _____

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

☐Yes / No☐Recreational drugs
☐Yes / No☐Over-the-counter medicines
☐Yes / No☐Weight loss medications
☐Yes / No☐Cortico - Steroids
☐Yes / No☐Tobacco in any form
☐Yes / No☐Alcohol
☐Yes / No☐Bisphosphonate (Fosamax)
☐Yes / No☐Antibiotics
☐Yes / No☐Supplements
☐Yes / No☐Aspirin

Please list all medications you are currently taking _____

VI. Women only *(Please circle Yes or No for each)*

☐ Yes / No☐**Are you or could you be pregnant? If YES, what month?** _____
☐ Yes / No☐**Are you nursing?**
☐Yes / No☐**Are you taking birth control pills?**

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

☐Yes / No☐**Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____
_____

☐Yes / No☐**Have you ever been pre-medicated for dental treatment?**
If YES, why _____

☐Yes / No☐**Have you ever taken Fen-Phen?**
If YES, when _____

☐Yes / No☐**Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date
_____	_____	_____	_____

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental History Form

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit? _____/_____/_____ Reason for the Visit? _____

Date of Last Dental X-rays? _____/_____/_____

Former Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

At-Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes/No

If YES, which kind: _____

Do you use any other dental home care products? Yes/No

If YES, which kind: _____

Circle Appropriate Answer (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No
   If YES, explain: _____

2. Do your gums bleed? Yes/No
   If YES, explain: _____

3. Are your teeth loose? Yes/No
   If YES, explain: _____

4. Do you wear dentures or partials? Yes/No
   If YES, explain: _____

5. Have you ever been told you have gum disease? Yes/No
   If YES, explain: _____

6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No
   If YES, explain: _____

7. Have your ever had any clicking, popping or discomfort in the jaw? Yes/No
   If YES, explain: _____

8. Do you brux or grind your teeth? Yes/No
   If YES, explain: _____

9. Do you wear an occlusal guard? Yes/No

10. Have you ever had orthodontic treatment (braces) before? Yes/No
    If YES, explain: _____

11. Do you have dry mouth? Yes/No
    If YES, explain: _____

12. Does food or floss catch between your teeth? Yes/No
    If YES, explain: _____

13. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No
    If YES, explain: _____

14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
    If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? Yes/No
    If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
    If YES, explain: _____

17. Are you happy with your smile? Yes/No
    If NO, please explain: _____

18. What would you change about the present condition of your mouth? _____
    _____

19. Is there anything else you would like us to know about your dental health or dental history? Yes/No
    If YES, explain: _____

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 dental 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.

Signature of Patient (Parent or Guardian)	**Date**
Signature of Dentist	**Date**

(6/2015)

Notice of Privacy Practices

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

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect 12/12/2017 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. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care: We may use or disclose 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, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our 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 of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health: We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access: You have the right to look at or get copies of your 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 practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your 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 and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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 your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Harveen Singh, DDS
Telephone: (818)842-0709 Fax: (818)842-1646
Email: harveensinghdds@gmail.com
Address: 500 E. Olive Ave Ste 640, Burbank, CA 91501

If you are concerned that we may have violated your privacy rights, or 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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Harveen Singh, DDS complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the _____ [name of practice] Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

SUBMIT