ALISO Smiles
Sajit J. Patel DMD

Date: _____

How did you hear about our office? _____

NEW PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Name: _____ _____ _____
Last First Preferred
Birth Date: _____ SSN: _____ ☐ Male ☐ Female

Email Address: _____

Cell: _____ Home: _____ Work: _____

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

Family Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Minor ☐ Other

Occupation: _____ Employer: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ _____ _____
Last First Relationship
Birth Date: _____ SSN: _____ ☐ Male ☐ Female

Cell: _____ Home: _____ Work: _____

Address (if different): _____ City: _____ State:____ Zip: _____

Occupation: _____ Employer: _____

DENTAL HISTORY

- Are you having dental discomfort today? Yes No
- Are you missing any teeth other than wisdom teeth or Orthodontic extractions? Yes No
- Have these missing teeth been replaced? Yes No
- Does it hurt to bite or chew? Yes No
- Do you clench or grind your teeth? Yes No
- Do you wear a night guard or splint? Yes No
- Are you concerned about gum disease? Yes No
- Does dental work make you nervous? Yes No → Please describe _____
- Do you have any concerns about the appearance of your teeth? Yes No
- Do your gums bleed when you brush or floss? Yes No

Name of previous dentist _____
City _____ State _____
Reason for changing _____
_____
How long since your last dental visit and what type of treatment was done? _____
_____

How do you feel about the condition of your smile?
Check one: ☐ Great ☐ Good ☐ Fair ☐ Poor

MEDICAL ALERTS & HISTORY

Name of Physician: _____ Phone: _____ Last visit: _____

PLEASE CHECK: Do you have allergies to the following items?

Y	N	Aspirin	Y	N	Hay Fever	Y	N	Sulfa
Y	N	Codeine	Y	N	Iodine	Y	N	Tetracycline
Y	N	Epinephrine	Y	N	Latex	Y	N	Ibuprofen
Y	N	Erythromycin	Y	N	Penicillin	Y	N	Other allergies

PLEASE CHECK: Do you have a history of any of the following conditions?

Y	N	Anemia	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse
Y	N	Angina	Y	N	Head Injuries	Y	N	Nervous Disorders
Y	N	Arthritis	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Artificial Joints	Y	N	Heart Disorders	Y	N	Pregnancy
Y	N	Artificial Heart Valves	Y	N	Heart Murmur	Y	N	Radiation Therapy
Y	N	Aspirin Therapy	Y	N	Heart Pacemaker	Y	N	Respiratory/breathing Problems
Y	N	Asthma	Y	N	Hepatitis: A B C	Y	N	Rheumatic Fever
Y	N	Cancer	Y	N	Herpes	Y	N	Rheumatism
Y	N	Chemotherapy	Y	N	High Blood Pressure	Y	N	Sinus Problems
Y	N	Coumadin	Y	N	High Cholesterol	Y	N	Stomach Problems
Y	N	Diabetes	Y	N	HIV/AIDS	Y	N	Stroke
Y	N	Epilepsy or Seizures	Y	N	Jaundice	Y	N	Substance Addictions
Y	N	Excessive Bleeding	Y	N	Kidney Disease	Y	N	Thyroid Problems
Y	N	Excessive thirst	Y	N	Liver Disease	Y	N	Tuberculosis
Y	N	Fainting or Dizziness	Y	N	Lung Disease	Y	N	Tumors
Y	N	Fever Blisters/Cold Sores	Y	N	Mental Disorders	Y	N	Ulcers
						Y	N	Venereal Disease

WOMEN ONLY:

Please check all that apply: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

EVERYONE:

- Have you ever been required to take pre-appointment medication or antibiotics? If so, explain:_____

_____

- Pharmacy name, location and phone number: _____
- Do you have any health problems that were not listed above or need further clarifications? If "Yes" please describe:

_____

- Are you now under the care of a physician? If "Yes", please describe: _____
- Have you been admitted to a hospital or needed emergency care during the past two years)? If "Yes", please describe:

_____

- Are you taking any medications or herbals? If "Yes", please describe: _____
- Have you or do you use tobacco? If "Yes", please describe: _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date _____

Signature of patient, parent or guardian

X _____ Date _____

Signature of Dentist

Patient Name: _____
Phone Number: _____
Date: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber: _____
Subscriber Birth Date: _____ ID#: _____ Group#: _____
Subscriber Address: _____
City: _____ State: _____ Zip Code: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name: _____
Insurance Company Address: _____
City: _____ State: _____ Zip Code: _____

Subscriber Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber: _____
Subscriber Birth Date: _____ ID#: _____ Group#: _____
Subscriber Address: _____
City: _____ State: _____ Zip Code: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name: _____
Insurance Company Address: _____
City: _____ State: _____ Zip Code: _____

Subscriber Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned carriers and assign directly to Dr. Patel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Patel may use my health care information and my disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____
Signature of Patient, Parent, Guardian or Personal Representative Date

Acknowledgement of Receipt of Notice of Privacy Policy

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and / or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I, (Patient Name) _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Signature/Parent Signature Date

HIPAA Acknowledgement of Receipt of the Notice Privacy Practices. This form does not constitute legal advice and covers only federal, not state, law.

Release of Information

Assignment of Insurance Benefits
I authorize & request my insurance company pay my benefits directly to Dr. Patel.

Photography Release
I authorize Dr. Patel, and his staffs, to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options. I authorize Dr. Patel and his employees to release any information regarding my dental/medical history, diagnosis, or treatment to third party payors and/or other health professionals.

Additionally, my information (medical/dental history, diagnosis, and treatment) can be discussed and shared with:

Myself only: _____
Spouse (name): _____
Children (name(s)): _____
Parent(s) (name(s)): _____
Other (name(s)): _____

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ○ The patient refused to sign
- ○ Due to an emergency it was not possible to obtain an acknowledgment
- ○ We were not able to communicate with the patient
- ○ Other (Please provide specific details)

_____
_____
_____
_____

_____
Employee Signature

_____
Date

General Consent

EXAMINATION AND X-RAYS: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.
DRUGS, MEDICATION AND SEDATION: I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and /or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effects treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating dentist is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

*X*_____ _____

Patient Signature/Parent Signature Date

HIPAA 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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 9/23/2013, 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 to 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 or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, 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, counterintelligence, and other national security activities. We may disclose to correctional institution or 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 or 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 once in a 12-month period, we may charge you a reasonable, 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 your 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 handled under the alternative means or location you request. We will accommodate all 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 your 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. We will provide you with the address to file your complaint with 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.

Contact Officer: Sajit Patel DMD
Telephone: 949-916-7800
Address: 26711 Aliso Creek Road, Suite 200 D, Aliso Viejo, CA, 92656