



# 6. MEDICAL HISTORY

Do you require pre-medication?  Yes  No  Don't know

Previous Dentist: Have you taken any medication or drugs during the past two years? .....Yes No

Are you taking any medication, drugs or pills now? .....Yes No

If yes, please list name and dosage \_\_\_\_\_

Are you taking any Blood Thinners (Aspirin, Warfarin (Cumadin) Plavix, Xarelto)?.....Yes No

If yes, please list name and dosage \_\_\_\_\_

Have you ever taken or are currently taking Biophosphonates (Actonel, Boniva, Fosomax) or Prolia or Denosuab ..... Yes No

If yes, please list name and dosage \_\_\_\_\_

Have you ever taken prescription medications for weight loss (diet pills?) .....Yes No

If yes, which one and for how long \_\_\_\_\_

If yes, to any on the above, did you have a medical exam for heart issues? .....Yes No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? .....Yes No

If yes, please list: \_\_\_\_\_

Have you been a patient in the hospital during the past five years? .....Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)....	Yes	No	Diabetes .....	Yes	No	Hepatitis C .....	Yes	No
Chest Pain .....	Yes	No	Thyroid Problems .....	Yes	No	Venereal Disease .....	Yes	No
Congenital Heart Disease.....	Yes	No	Glaucoma .....	Yes	No	A.I.D.S. ....	Yes	No
Heart Murmur .....	Yes	No	Contact lenses.....	Yes	No	H.I.V. Positive .....	Yes	No
High Blood Pressure.....	Yes	No	Emphysema.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Chronic Cough.....	Yes	No	Blood Transfusion.....	Yes	No
Artificial Heart Valve .....	Yes	No	Tuberculosis .....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Asthma .....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever .....	Yes	No	Hay Fever .....	Yes	No	Bruise Easily .....	Yes	No
Arthritis/Rheumatism .....	Yes	No	Latex Sensitivity.....	Yes	No	Liver Disease.....	Yes	No
Cortisone Medicine.....	Yes	No	Allergies or Hives.....	Yes	No	Yellow Jaundice.....	Yes	No
Swollen Ankles .....	Yes	No	Sinus Trouble .....	Yes	No	Neurological Disorders .....	Yes	No
Stroke .....	Yes	No	Radiation Therapy .....	Yes	No	Epilepsy or Seizures.....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Chemotherapy .....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Kidney Trouble .....	Yes	No	Tumors .....	Yes	No	Nervous/Anxious .....	Yes	No
Ulcers .....	Yes	No	Hepatitis A (infectious) B (serum)...	Yes	No	Psychiatric/Psychological Care .....	Yes	No

Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list: \_\_\_\_\_

**Women.** Are you: **Pregnant?** Yes, \_\_\_Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that this practice provides space, equipment, support personnel, and administrative services to facilitate each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgment in the nature and manner of dental care and treatment provided, I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THE DENTAL MANAGEMENT COMPANY.

\_\_\_\_\_  
Signature of patient (parent or guardian)      Date

\_\_\_\_\_  
Signature of dentist \_\_\_\_\_      Date

## X11. 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's initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



## OFFICE FINANCIAL POLICY

At **SOUTH COAST DENTAL SPECIALTIES**, we believe that you deserve the best care. That's 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 dental benefits, but some 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 your 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 given by a 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 expense figures you may require.

***We bill your insurance as a "courtesy". If your insurance does not pay within 90 days, SOUTH COAST DENTAL SPECIALTIES 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 between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.***

**Our policy requires payment in full for all services rendered at the time of visit.** If your balance is not paid within 90 days of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in collecting your account.

***Broken Appointments: A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 24-hour notice to avoid a \$25 cancellation fee (emergencies are an exception). For Saturday appointments we require a 48-hour notice.***

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

Date

Printed Name

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Acknowledgement of Receipt of
HIPAA Notice of Privacy Practices

30190 Town Center Drive, Suite B, Laguna Niguel, CA 92677 • 949/ 363-2540 • Fax: 949/ 363-3352

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgement. (please print)

PATIENT'S LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

South Coast Dental Specialties
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW
HEALTH INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS
INFORMATION. PLEASE REVIEW IT
CAREFULLY.

We are required by law to maintain the
privacy of protected health information, to
provide individuals with notice of our legal
duties and privacy practices with respect to
protected health information, and to notify
affected individuals following a breach of
unsecured protected health information.
We must follow the privacy practices that
are described in this Notice while it is in
effect. This Notice takes effect 01/01/2016,
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.

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.

X

Patient / Parent's Signature:

Date: \_\_\_\_\_

Patient Representative's Signature:

Date: \_\_\_\_\_

**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.

**Our Privacy Official:** Debbie

Canu: Debbie Canu

**Telephone:** (949) 600-7046 Fax: (949) 600-9899

**Address:** 27 Spectrum Pointe Drive, Suite 308, Lake Forest, CA 92630-9899

**E-mail:** dcanu@socaldentalpartners.com