WELCOME

South Coast Dental Specialties

949-363-2540

1. ABOUT YOU

Today's Date:_____/_____/_____

Patient Name: _____

Last First MI

What You Prefer To Be Called:_____

❑ Male ❑ Female

Birth Date:_____/_____/____ Age: _____

SS #: _____–_____

Mailing Address: _____

CITY_____ STATE_____ ZIP_____

Home Phone #: _____

Work Phone #:_____ Ext: _____

Cell Phone #:_____

E-mail Address:_____

Referred By:_____

Employer:_____How Long?_____

Employer's Address:_____

_____

City State Zip

Occupation:_____

Status:

❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Seperated ❑ Widowed

Spouse's Name:_____

Do you have children? ❑ Yes ❑ No How many?_____

2. INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address: _____

_____

CITY_____STATE_____ ZIP_____

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Date of Birth:_____/_____/_____

Insured's Employer:_____

Secondary Dental Insurance

Co. Name:_____

Address: _____

_____

CITY_____STATE_____ ZIP_____

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local or Policy #):_____—___

Insured's Name:_____

Relation:_____Date of Birth:_____/_____/_____

Insured's Employer:_____

3. ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY_____ STATE_____ ZIP_____

SS #: _____

Driver's License #:_____

Work Phone #:_____

Payment Method: ❑ Cash ❑ Check

_____ / _____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4. IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

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 Biophoshonates (Actonel, Boniva, Fosomax) or Prolia or Denosuab ..... Yes No
If yes, please list name and dosage _____
Have you ever taken prescription medications for weight losss (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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

South Coast Dental Specialties

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**

_____ _____ _____

South Coast Dental Specialties

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 _____ Date: _____ _____ Date: _____

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

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