Effective June 2007

Santa Rosa Dental

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR DENTAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY

Santa Rosa Dental uses health information about you for treatment, payment and health care operations. Your health information is contained in paper and electronic records that are the property of OCLDC.

Use or Disclosure of Your Health Information

For Treatment:
OCLDC will use your health information within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your dental health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

For Payment:
OCLDC may use and disclose your health information to others for purposes of payment for treatment and services that you received. The information on the claim will include information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. We may do this with insurance forms filed for you in the mail or sent electronically.

For Health Care Operations:
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance certification, licensing or credentialing activities.

In Patient Reminders:
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are in an important part of our philosophy of partnering with our patients to be sure they can receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding post-cards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates:
We have contracted with one or more third parties (referred to as business associates) to use and disclose your health information to perform services for us, such as billing services. We will obtain each associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES
Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Require by Law:
We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect:
We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required by law to make the disclosure. We will promptly inform you that such disclosure has been made unless the privacy Official determines that informing you would not be in your best interest.

Public Health and National Security:
We may be required by law to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement:
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Worker's Compensation Purposes
We may disclose you health information as require or permitted by State or Federal workers compensation laws.

Judicial and Administrative Proceedings
We may disclose your health information in administrative or judicial proceedings in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental uses and disclosures
We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this notice.

Health oversight activities
We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To avert a serious threat to health or safety
We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or the public.

To The U.S. Department of Health and Human Services (HHS)
We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to condition. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation
We may disclose your health information to a coroner for indentification purposes or funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
Other than being asked by Federal, State, or Local law require, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENTS RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restriction on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by the federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy You Health Information
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend your health information:
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the changes.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during a 12 month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12 month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have a right to obtain a copy of this notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and provide to you or your personal representative with this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting you complaint to our Privacy Officer.

PATIENT ACKNOWLEDGEMENT

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you. We would appreciate you acknowledging your receipt of our policy by signing this form. You may also request a copy of this form for you records.

Patient Name _____

Patient/Representative

Signature _____

Date _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.
Effetive June 2007

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (of the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X_____ _____

Signature of patient or parent if minor Date

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, please ask for assistance.

Payment in full at each appointment

_____ Cash
_____ Personal Check
_____ Credit Card Visa MasterCard
Card# _____ Expiration Date: _____

_____ Care Credit- If you choose this option, please inform the receptionist to give you more information and an application.

_____ _____

Signature of patient/ Responsible Party Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have any questions at anytime, please ask us, we are always happy to help.

Dental Care Credit- This is a separate line of credit which does not affect the balances of your other credit cards. Unlike other credit cards, there are no annual fees. This monthly payment plan does not require payment now, nor the use of your bank card. Processing your application will only take a few minutes.

Santa Rosa Dental

PATIENT DENTAL HISTORY

THANK YOU FOR SELECTING SANTA ROSA DENTAL
WE WILL STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE.

HOW DID YOU HEAR ABOUT US _____

WHOM MAY WE THANK FOR REFERRING YOU _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN...WHEN...WHERE _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

ARE YOU HAPPY WITH APPEARANCE AND COLOR OF YOUR TEETH? IF NOT, EXPLAIN: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

Signature of Patient or Parent/Guardian if Minor *Date*

Signature of Patient or Parent/Guardian if Minor *Date*

Doctor's Signature *Date*

CONFIDENTIAL

CONSENT

Date_____ SS/HIC/Patient ID#_____

Patient Name_____Date of Birth_____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

☐ **1. Work to be Done**

I understand that I am having the following work done: Fillings____ Bridges____ Crowns____ Extractions_____ Impacted teeth removed_____ General Anesthesia_____ Root Canals_____ Other Xrays

(Initials_____)

☐ **2. Drugs and Medications**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock (severe allergic reaction).

(Initial_____)

☐ **3. 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 /all changes and additions as necessary.

(Initials_____)

☐ **4. Removal of Teeth**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initial_____)

☐ **5. Crown, Bridges and Caps**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which maybe come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initial_____)

☐ **6. Detures, Complete or Partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials_____)

☐ **7. Endodontic Treatment (Root Canal)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I undertand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)

(Initial_____)

☐ **8. Periodontal Loss (Tissue & Bone)**

I understand that I have a serious condition, causing gum and bone infection or loss and that if can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initial_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____

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

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

Santa Rosa Dental

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	☐	☐
PLEASE EXPLAIN. _____		
7. ARE YOU TAKING ANY MEDICINE(S)	☐	☐
INCLUDING NON-PRESCRIPTION MEDICINE.	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐

	YES	NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. DO YOU USE TOBACCO	☐	☐
14. ARE YOU WEARING CONTACT LENSES	☐	☐
15. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAIN	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐

	YES	NO
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐

Doctor's Signature _____ *Date*

Doctor's Signature _____ *Date*

Doctor's Signature _____ *Date*

Signature of Patient, Parents or Guardian _____ *Date*