PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐M ☐F ☐Non-B Married: ☐Y ☐N ☐D-P

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMesssage

Preferred Contact Method for Confirmations: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMesssage

Preferred Contact Method for Recall: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMesssage

Student status if dependent over 19 (for ins): ☐ Nonstudent ☐ Fulltime ☐ Parttime

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

DENTAL INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

EMERGENCY CONTACT

Name/Relationship: _____

Phone Number: _____

MEDICAL HISTORY

Your Name:	Date of Birth:	
Physician's Name:		
Physician's Phone #:		
1. When was your last complete physical exam?		
2. Have you been a patient in a hospital during the past two years?	Yes☐	No ☐
3. Are you allergic to (i.e. itching, rash, swelling) or made sick by penicillin, tetracycline, codeine, aspirin, ibuprofen (Advil), acetaminophen (Tylenol), or any other medications?	Yes☐	No ☐
4. Have you ever had any excessive bleeding requiring special treatment?	Yes☐	No ☐
5. Do you bruise easily?	Yes☐	No ☐
6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	Yes☐	No ☐
7. Do your ankles swell during the day?	Yes☐	No ☐
8. Do you use more than 2 pillows to sleep?	Yes☐	No ☐
9. Have you lost or gained more than 10 pounds in the past year?	Yes☐	No ☐
10. Do you ever wake up from sleep short of breath?	Yes☐	No ☐
11. Are you on a special diet?	Yes☐	No ☐
12. Has your medical doctor ever said you have a cancer or a tumor?	Yes☐	No ☐
Women: Are you pregnant now?	Yes☐	No ☐
Are you practicing birth control?	Yes☐	No ☐
Do you anticipate becoming pregnant?	Yes☐	No ☐

Please mark any of the following conditions if you presently have them or if you have had them in the past:

- ☐ Mitral Valve Prolapse
- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris (chest pains)
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ X-ray or Cobalt Treatment
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone or Steroid medication
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Hemophilia
- ☐ Sexually Transmitted Disease
- ☐ Cold Sores
- ☐ Herpes
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Sickle Cell Disease
- ☐ Fen-Phen or Redux (diet medications)
- ☐ Tobacco Use

Please initial and continue on the next page.

_____
Patient initials

MEDICAL HISTORY

In the space below, please list all medications including over the counter medications, vitamins, and herbals.

Do you have any disease, condition, or problem not listed on this health history form? YES ☐ NO ☐

To the best of my knowledge, all of my responses to the questions on this medical history form are true and correct. If I have any change in my health, or if my medications change, I will inform the doctor at my next appointment.

_____ _____

Date Signature of patient, parent, or guardian

Additional Notes:

DENTAL HISTORY

Dentist's comments:

Your Name: Date of Birth:
What is the purpose of your visit?
Are you aware of any specific problem?
How long has it been since your last dental visit?
What was done at that time?
How long has it been since your teeth were cleaned?
Have you made regular dental visits? ☐ Yes ☐ No
If yes, how often?
Name of Previous Dentist:
Have you lost any teeth or had any removed? ☐ Yes ☐ No
Have you had any teeth replaced? ☐ Yes ☐ No
If yes, how have they been replaced? *(circle all that apply)* Fixed bridge ☐ Removable bridge ☐ Denture ☐
Are you happy with the replacement? ☐ Yes ☐ No
Would you like to know about permanent replacements? ☐ Yes ☐ No
Have you ever had complications with previous dental treatment? ☐ Yes ☐ No
If yes, please comment:
Do you clench or grind your teeth? ☐ Yes ☐ No
Does your jaw click or pop? ☐ Yes ☐ No
Do you frequently experience pain or soreness in the muscles of your face or around your ear? ☐ Yes ☐ No
Do you have frequent headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Does food get caught between your teeth? ☐ Yes ☐ No
Are any of your teeth sensitive to *(circle all that apply):* Hot ☐ cold ☐ sweets ☐ pressure ☐
How often do you brush your teeth?
Do you use dental floss or toothpicks? ☐ Yes ☐ No
Are you happy with the appearance of your teeth? ☐ Yes ☐ No
Do you have any discolored teeth that bother you? ☐ Yes ☐ No
How do you feel about your teeth in general?
Have you ever had gum treatment or surgery? ☐ Yes ☐ No
Have you had any orthodontic care (braces)? ☐ Yes ☐ No
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ☐ Yes ☐ No
Do you have any other questions or concerns ☐ Yes ☐ No

I certify that the above information is complete and accurate:

_____ _____

Date Signature of patient, parent, or guardian

LAKESHORE FAMILY DENTISTRY

Office Policies

It is our mission to provide the best dental care possible and to be helpful regarding office issues. To do so, we need your partnership and a clear understanding of our office policies. Therefore, we ask that you read and consider the following.

Insurance Policies

Note to patients with insurance: WE ARE IN-NETWORK PROVIDERS FOR DELTA DENTAL PPO AND PREMIER ONLY for all other dental insurance plans we are considered out-of-network, which means that your benefit levels and co-payments could be affected, so please check with your insurance for coverage details.

If you have a dental insurance plan, we are happy to process any insurance claim as a service to you and accept the assignment of your insurance benefits. However, your deductible and the *estimated* co-payment are due and payable when services are rendered.

We shall make an effort to inform you of your payment before your dental treatment. In some instances, additional charges may arise on the appointment date from additional unexpected treatment performed.

We will estimate your deductible and the portion not covered by your insurance. Our estimates may differ somewhat from your insurance company's calculations; therefore the amount due in our office may be adjusted accordingly. Please remember that any insurance reimbursement quoted is only an estimate and we cannot predict what the insurance company will do.

Your insurance coverage is a unique contract between you, your employer, and your insurance company. Not all services are covered by every insurance plan. Please be aware that our staff does its best to provide you with the correct information regarding your insurance, but we cannot possibly know all of the details of your policy. Ultimately you are responsible for payment for the services we provide and any balance remaining after the Insurance Company has paid the claim.

Most companies pay a percentage of our accepted fees. The percentage may vary by the type of procedure. Other companies reimburse based on a percentage of an arbitrary "schedule" of fees, which bears no relationship to the current standard cost in this area.

While we do our best to work within your insurance limits and/ or inform you of services not covered by your insurance plan, our main goal is to recommend the absolute best treatment available based on your individual dental needs. We do not base treatment recommendations on what your insurance company will cover.

We strive to bill correctly, and we are willing to correct any errors. However, the reality is insurance may still not cover some services, even if they are medically appropriate and billed correctly.

Returned Checks and Collection Procedures

* All returned checks are subject to a $35.00 non-sufficient funds fee.

* We reserve the right to forward any balance past due by 90 days to a third-party collection agency for collection purposes.

* A service charge will be added if a balance due is not paid within 60 days. The percentage rate is 1.5% per month and 18% annually.

For your convenience, we accept cash, checks, Visa, MasterCard, Discover, and American Express.

Appointment Policies

Your appointment time is reserved exclusively for you. Please be considerate of others and give us 48 hours notice for cancellation or rescheduling of your appointment. Please call us; **do not send emails**. If an appointment is not kept or canceled without the proper notice you will be charged a fee of $50.00 per hour. If you do not arrive for a scheduled appointment, you will be charged a $ 75.00 per hour No-Show fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, Please do not hesitate to ask our office manager. We are here to help you.

_____

Date

_____

Patient or Guardian's Signature

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect Jan. 1, 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 the 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.

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.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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 healthcare 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 was 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. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 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 healthcare. 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 will not use your health information for marketing communications without your written authorization.

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

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you $0.00 for each page, $0.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

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 how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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: Lakeshore Family Dentistry

Telephone: (510) 444-4331 Fax: (510) 444-4331

E-mail: 3309lakeshoredental@gmail.com

Address: 3309 Lakeshore Ave. Oakland, CA 94610

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Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office 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)

_____

_____

_____

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