

PATIENT INFORMATION

Date _____

Mr Mrs Ms Dr

Patient _____
First Middle initial Last

Address _____
Street

City State Zip

Patient's Phone _____
Home Work

Cell Pager

Sex M F Age Birthdate

Single Married Widowed Separated Divorced

Soc. Sec. No. _____

Occupation _____

Employer _____

Employer's Address _____

Employer Phone(____) _____

Patient's Dental Insurance Carrier _____

Group # _____ Union Local # _____

Spouse's Name _____
(Parent) First Middle initial Last

Spouse's Address (if different) _____
Street

City State Zip

Spouse's Phone _____
Home Work

Spouse's Date of Birth _____

Spouse's Employer _____

Name (business name if self-employed)

Street City State Zip

Spouse's Occupation _____

Spouse's Soc. Sec. No. _____

Spouse's Dental Insurance Carrier _____

Group# _____ Union Local # _____

Whom may we thank for referring you?

Name Address

Party responsible for this account _____

Billing Address (if different from above) _____

Patients are always responsible for payment of their bill EVEN if they have dental insurance. It is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service. We will assist you in every way possible with your insurance carrier. I understand that a 1.5% finance charge (18% annually) will be added to all balances over 90 days.

RELEASE AND ASSIGNMENT

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

Signed _____ Date _____

CONSENT FOR PROFESSIONAL SERVICES

I hereby authorize Gary J. Schmid, D.D.S., and/or the dentist in charge of my care and their auxiliaries to administer any treatment, anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case after discussion of the proposed treatment, alternatives and implications. I understand that results are not guaranteed or warranted and cannot be guaranteed or warranted.

Date _____ Signed _____

DENTAL HISTORY

Please circle "Y" or "N" to indicate if you have any of the following

Reason for today's visit _____	Bad breath	Y	N	Jaw pain or tiredness	Y	N
_____	Bleeding gums	Y	N	Chew on one side only	Y	N
Former Dentist _____	Do you smoke	Y	N	Clicking or popping jaw	Y	N
City/State _____	Dry Mouth	Y	N	Sensitivity to hot, cold or sweets	Y	N
Date of last dental visit _____	Mouth breathing	Y	N	Sensitivity to biting	Y	N
Date of last dental X-rays _____	Pain around ear	Y	N	Grinding or clenching of teeth	Y	N

HEALTH HISTORY

Your Name _____
 Physician's Name _____ Phone # _____ Date of Last Visit _____

Please circle "Y" or "N" to indicate if you have had any of the following:

AIDS/HIV Positive	Y N	Epilepsy	Y N	Psychiatric Care	Y N
Anemia	Y N	Fainting or dizziness	Y N	Radiation Treatment	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Respiratory Disease	Y N
Artificial Heart valves	Y N	Headaches	Y N	Rheumatic Fever	Y N
Artificial Joints	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Asthma	Y N	Hepatitis	Y N	Shortness of Breath	Y N
Back Problems	Y N	Type _____	Y N	Sinus Trouble	Y N
Bleeding abnormally, with	Y N	Herpes	Y N	Skin Rash	Y N
Extractions or surgery	Y N	High Blood Pressure	Y N	Stroke	Y N
Blood disease	Y N	Jaundice	Y N	Swelling of Feet or Ankles	Y N
Cancer	Y N	Jaw Pain	Y N	Thyroid Problems	Y N
Chemical Dependency	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Chemotherapy	Y N	Low Blood Pressure	Y N	Tuberculosis	Y N
Circulatory Problems	Y N	Mitral Valve Prolapse	Y N	Tumor or growth on head	Y N
Congenital Heart Lesions	Y N	Nervous Problems	Y N	or neck	
Cortisone Treatments	Y N	Pacemaker	Y N	Ulcer	Y N
Cough, persistent or	Y N	Women:		Venereal Disease	Y N
bloody		Are you pregnant?	Y N		
Diabetes	Y N	Due date _____		Unexplained weight loss	Y N
Emphysema	Y N	Are you nursing?	Y N		Y N

Do you have any disease, condition or problem not listed above that you think I should know about? _____

MEDICATIONS		ALLERGIES	
Please list medications you are currently taking:		Circle if allergic to item	
		Aspirin	Local Anesthetic
		Barbiturates	Penicillin
		Codeine	Sulfa
Have you ever taken Fen-Phen? Y N		Iodine	Other _____
Have you ever taken Redux? Y N		Latex	
Have you ever taken Fosamax, Boniva, or Actonel? Y N			
Have you ever been given Zometa, Aredia or Didronel? Y N			
DATE	PATIENT'S/PARENT'S SIGNATURE	DOCTOR'S SIGNATURE	

UPDATES (to be filled in at future appointments)
 Has there been any change in your health since your last dental appointment? Y N
 For what conditions? _____
 Are you taking any new medications? _____ If so what? _____

Patient's signature _____ Date _____
 Doctor's signature _____ Date _____

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 4/14/2003, 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 \$0.50 for each page, \$15.00 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: Gary J. Schmid D.D.S.

Telephone: (310)373-8941

Fax: (310)373-3545

E-mail: _____

Address: 3640 Lomita Blvd. #202, Torrance, Ca. 90505

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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)

