About You

Patient Name_____

Prefer to be called_____ ☐ Male ☐ Female

DOB_____ Age_____ Referred by_____

Address _____

Mailing Adress _____

City _____ St____ Zip_____

Phone: Home _____ Cell _____

Work _____

Email_____

Preferred to be reached at

_____

Status: ☐ Minor ☐ Single ☐ Married

☐ Divorced ☐ Widowed

Spouse's Name_____

Account Info: Person ultimately responsible for account.

Name _____ Relation _____

Billing Address_____

SSN# _____ Sub DOB_____

Phone: Home _____

Work/Cell_____

In Event of Emergency: Whom should we contact?

Name _____ Relation _____

Phone: Home _____

Work/Cell_____

Doctor's Name + Phone _____

Employer_____ How long _____

Address _____

City_____ St____ Zip_____

Occupation_____

Dental Information: Please √ any of the following problems that apply:

☐ Popping, Clicking, Locking Jaw	☐ Lost/Broken Fillings	☐ Broken/Chipped Tooth	☐ Teeth Grinding
☐ Red, Swollen, or Bleeding Gums	☐ Sensitive Teeth/Gums	☐ Sores/Blisters Around Mouth	☐ Stained Teeth
☐ Pain?_____ How long?_____	☐ Other_____		

Medical History: Please √ any of the following diseases, medical conditions, or procedures that apply:

☐ Heart Attack/Stroke	☐ Anemia	☐ Hepatitis/Liver Problem	☐ Back/Neck Problems
☐ Heart Disease	☐ Bleeding Problems	☐ Thyroid Problems	☐ Arthritis/Rheumatism
☐ Heart Surgery/Pacemaker	☐ Lung Problems	☐ Kidney Problems	☐ Cancer/Tumors
☐ Heart Murmur	☐ Difficulty Breathing	☐ Shingles	☐ Leukemia
☐ Rheumatic or Scarlet Fever	☐ Asthma or Emphysema	☐ Nervousness	☐ Artificial Bone/Joints
☐ Mitral Valve Prolapse	☐ Chronic Bronchitis or COPD	☐ Psychiatric Problems	☐ X-Ray/Cobalt Treatment
☐ Artificial Valve	☐ Tuberculosis	☐ Severe Frequent Headaches	☐ Chemotherapy
☐ Congenital Heart Defect	☐ Sinus Problems	☐ Fainting/Seizures/Epilepsy	☐ HIV+/AIDS/ARC
☐ Chest Pain	☐ Stomach Problems/Ulcers	☐ Jaw Problems TMJ/TMD	☐ Alcohol/Drug Abuse
☐ High/Low Blood Pressure	☐ Diabetes/Low Blood Sugar	☐ Glaucoma	☐ Others_____

- Have you ever taken any of the following medications?
  (Please √ all the apply or circle *none*)
  ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelid ☐ Didronel ☐ Aredia ☐ Zometa ☐ Bonefos ☐ Phen-Fen ☐ None
- Are you taking any medications, including non-prescriptions?
  ☐ Yes ☐ No If so, please list:_____
- Please list any other surgeries or medical conditions you have or ever had. _____
- Do you use tobacco? ☐ Yes ☐ No Method?_____ Amount?_____ How long?_____
- Are you allergic to any of the following?
  ☐ Penicillin/Amoxicillin ☐ Ibuprofen/Motrin/Advil ☐Aspirin ☐ Dental Anesthetics ☐ Any metal (nickel, mercury)
  ☐ Latex ☐ None ☐ Other _____

For Women Only

- Are you using birth control? ☐ Yes ☐ No If so, which method? _____
- Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Authorization

I certify that I have read and understand all of the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records for any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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. I understand that if the account is not paid within 90 days of the date of service and no financial arrangements have been made, I am responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I also understand that it is my responsibility to cancel appointments and if I fail or miss and appointment, I can be charged a minimum $30 per each hour of the missed appointment.

Signature of Patient (or parent/guardian if minor) _____ Date _____

Updated
Date: 4-5-2010

Notice of Privacy Policy

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.

Jason J. Lee DDS
(Name of Dental Practice)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location and provide patients with a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice, at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy Policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA Plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use and disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs.
- **Marketing:** We will not use your health information for marketing purposes without your written consent.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, email, postcards, or letters.
- **Legal Requirements:** We may disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use of disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

Note: 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.

Date: 4-5-2010

Notice of Privacy Policy

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.

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.

  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

- 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the DHHS. We will provide you with the address to file your complaint with the DHHS 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 DHHS.

HIPAA Coordinator: Heather Olmsted

Telephone: 530-878-2224 Fax: 530-878-8169

Email: JJLeedds@gmail.com

Address: 7121 Placer Hills Rd Mv Ca 95722

Authorization to Disclose My Dental Information

I hereby authorize (previous dentist):

_____(_____)_____
Name of previous dentist Phone #

_____
Address

_____
City State Zip

to disclose to: **Jason J. Lee, D.D.S.**
P.O. Box 160
Meadow Vista, CA 95722
(530) 878-2224
(530) 878-8169 Fax

records and information pertaining to:

_____/_____/_____
Patient name (list other names used) Date of Birth

_____(_____)_____
Address Phone #

_____
City State Zip

I authorize release of my dental information including X-rays for the following purpose(s):_____.
This authorization shall become effective immediately and shall remain in effective for one year from the date of signature unless a different date is specified here_____/_____/_____.
Date

I may revoke this authorization in writing at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization. I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

_____/_____/_____
Patient or legally authorized individual signature Date

_____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)