PATIENT INFORMATION

CONFIDENTIAL Date _____

(PLEASE PRINT)

Name _____ Birth Date_____ Home Phone _____

Preferred Name_____ Cell Phone _____

Address_____ City _____ State_____ Zip _____

Circle One: Married Single Other

If patient is a minor, name of person responsible for this account_____

Relationship to patient _____

Patient or parent/guardian driver's license# _____

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you to our practice? _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for this account

Name _____

Employer Name_____ Occupation_____

Address_____ City _____ State_____ Zip _____

Work Phone_____

SIGNATURE

I certify that I have read and understand the information on both sides of this form. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information could jeopardize my health. 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, late fees, or interest charges incurred on my behalf or on behalf of my dependents.

x _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

PATIENT NAME_____ BIRTH DATE _____ DATE_____

DENTAL HISTORY

Do you have a specific dental problem? Describe:_____

_____

Have you had any trouble associated with any previous dental treatment? Explain: _____

_____

Have you had, or do you currently have, any of the following? (check appropriate boxes)

☐ sleep apnea device
☐ bleeding gums/gum disease
☐ orthodontic work
☐ loose teeth
☐ bruxing / grinding
☐ chipped teeth
☐ jaw popping/clicking/discomfort
☐ food catching in teeth
☐ esthetic concerns

MEDICAL HISTORY

Name of Primary Physician _____

Office Phone _____ Date of last exam_____

Have you ever been hospitalized or had an operation? Explain:_____

_____

Have you ever had a serious injury to your head or neck? Explain: _____

_____

Do you use any form of tobacco? (specify): _____

Are you taking any medications, pills, or drugs?

Please list: Medication Reason for taking

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR MATERIALS? List: _____

_____

WOMEN: (please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Have you had, or do you currently have, any of the following? (check appropriate boxes)

☐ Sleep Apnea
☐ AIDS/HIV Positive
☐ Heart Trouble/Disease
☐ Heart Murmur
☐ Irregular Heart Beat
☐ Angina/Chest Pain
☐ Heart Attack/Failure
☐ Congenital Heart Defect
☐ Mitral Valve Prolapse
☐ Artificial Heart Valve
☐ Heart Pace Maker
☐ High Blood Pressure
☐ Stroke
☐ Psychiatric Care
☐ Anemia
☐ Excess Bleeding
☐ Sickle Cell Anemia
☐ Hemophilia
☐ Leukemia
☐ Blood Transfusion
☐ Breathing Problem
☐ Frequent Cough
☐ Hay Fever
☐ Sinus Trouble
☐ Asthma
☐ Alzheimer's
☐ Emphysema
☐ Tuberculosis
☐ Cancer
☐ Radiation Therapy
☐ Chemotherapy
☐ Stomach/GI Problems
☐ Diabetes
☐ Liver Disease
☐ Hepatitis Type _____
☐ Back/Neck Pain
☐ Hearing Problems
☐ Glaucoma
☐ Tumors/Growths
☐ Nervousness
☐ Kidney Problems
☐ Thyroid Disease
☐ Arthritis/Gout
☐ Epilepsy/Seizures
☐ Fainting/Dizziness
☐ Rheumatism
☐ Pain in Jaw Joints
☐ Artificial Joint
☐ Drug Addiction
☐ Cold Sores
☐ Implants
☐ Shunts/Catheters

Have you ever had any serious illness or condition not listed above? Describe: _____

_____

Do you wish to talk to the dentist privately about any problem? _____

Burlingame Family Dentistry
Benjamin Brown, DMD

FINANCIAL POLICIES

Please initial by each policy statement to indicate you understand our office financial policies.

_____ Payment is expected the day services are rendered unless prior financial arrangements have been made.

_____ A charge will be made for broken, missed, or rescheduled appointments without 24 hours notice.

_____ As a courtesy to our patients, we will bill your dental insurance for you. Your dental insurance is a contract between you or your employer and the insurance company. We serve as an outside party that will bill the insurance company for you. You are responsible for all fees incurred.

_____ We will provide a treatment estimate for procedures prescribed by your dentist. Procedures needed and fees incurred are subject to change. We make every effort to formulate an accurate and appropriate treatment plan for each patient, but the required procedures to treat your teeth may change upon commencement of treatment.

I have read and agree to follow these financial policies for Burlingame Family Dentistry.

_____ _____

Patient Signature Date

Burlingame Family Dentistry
Benjamin Brown, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received and reviewed a copy of the Notice of Privacy Practices for Burlingame Family Dentistry.

Print PATIENT Name

PATIENT Signature or Parent/Guardian Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This can include, but is not limited to, calling in prescriptions to your pharmacy, discussing your case with specialists to whom we have referred you, and sending your x-rays to other dental offices involved in your dental treatment.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

PATIENT Signature or Parent/Guardian Signature Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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) _____

Burlingame Family Dentistry
Benjamin Brown, DMD

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 (PHI), 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 09/23/2013, 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.

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 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.

If you want more information about our privacy practices or have questions or concerns, please contact us at 503-244-8243; info@burlingamefamilydentistry.com