Orchard Dental Care
Dr. Saini

PATIENT INFORMATION ***(PLEASE FILL OUT COMPLETELY)***

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ PatientIs: ☐ PolicyHolder ☐ ResponsibleParty ☐ Child

Address: _____ City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Mobile _____

Email Address: _____

Birth Date: _____ Soc. Sec: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Student Status: ☐ Full Time ☐ Part Time

School /Employer Name: Preferred Pharmacy/Phone:

PARENT/GUARDIAN INFORMATION *(For minors 17yrs & younger)*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____ Relationship to Patient: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

PRIMARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)

Name of Insured: Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID/SSN: _____ Insured DOB: _____

Employer: Ins. Company:

Address: _____ Address: _____

City, State and Zip: City, State and Zip:

Phone: Phone:

SECONDARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)

Name of Insured: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID/SSN: _____ Insured DOB: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State and Zip: City, State and Zip:

Phone: Phone:

REFERRAL SOURCE (WHO CAN WE THANK?)

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____

PATIENT HEALTH HISTORY

Patient Name:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?Have	☐ Yes	☐ No	If yes, please explain:_____
you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	_____
Do you take, or have you taken Bisphosphonates **(Fosamax, Binosto)** ?	☐ Yes	☐ No	_____
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

WOMEN, ARE YOU…

Pregnant/Tryingtogetpregnant? ☐ Yes ☐ No Takingoralcontraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ARE YOU ALERGIC TO THE FOLLOWING…

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other Ifyes,pleaseexplain_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING…

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	DrugAddiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Press.	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthiritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes ,please explain:_____

IN CASE OF EMERGENCY CONTACT…

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____

MEDICAL HEALTH REVIEWED BY (DOCTOR): _____ DATE: _____

ORCHARD DENTAL CARE

DENTAL HISTORY

Reason for today's visit? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort jaw joint?(TMJ) ☐ Yes ☐ No

Are you under any stress (i.e. new job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week?_____brush/day?_____

Are you sensitive to heat, cold or anything else? ☐ Yes ☐ No

Have you lost any permanent teeth? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last: Cleaning?_____DentalVisit?_____

Why did you leave your previous dentist? _____

We offer a wide variety of services to enhance and keep your smile beautiful. Please notify our our friendly staff if you would like to discuss any of the following during your visit.

Take-home Bleaching Trays	Smile Makeover	Bonding
Partials/Dentures	Crowns & Bridge	Implant Crowns
Nightguard/Sportsguard	Sealants	Replace Silver Fillings
Bad Breath	Fixing Chipped Teeth	Straighter Teeth

Agreement to Receive Electronic Communication

Patient Name: _____

(Initial below)

I _____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging

____ Email

I would like to receive: Courtesy.

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

Orchard Dental Care- Dr.Saini 916-422-8332

Signature:_____ Date:_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) require that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below acknowledging you have received these forms from this office.

1. A copy of the Dental Materials Fact Sheet; and
2. Notice of Privacy Practices.

_____
PRINT NAME OF PATIENT/PARENT/GUARDIAN

X _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN

_____
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 (PleaseSpecify)

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT YOUMAYBEUSEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Smile Dental Services & Affiliated Dental Offices respectsyourprivacy.We understand that your personal health information is very sensitive.Wewillnotdiscloseyourinformationtoothersunlessyoutellusto do so, or unless the law authorizes or requires us to do so.

The Health Insurance Portability and Accountability of 1996 (HIPAA) requires all health care records and other individually identifiable health informationused or disclosed to usin anyform, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example,wemay needtoshareinformationwithotherhealthcareprovidersorspecialistsinvolvedinthecontinuationofyourcare.
- **Payment** means suchactivitiesasobtainingreimbursementforservices,confirmingcoverage,billingorcollectionactivities,and utilizationreview. Forexample,wemaydisclosetreatmentinformationwhenbillingadentalplanforyourdentalservices.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for trainingpurposes, orquality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with the payment of your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses a nd disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights regarding your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the Administration Office address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required to grant the request. But we will comply with any request granted
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations…or based on your previous authorization.
- The right to obtain a paper copy of this notice from us on request, even if you agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer Orchard Dental Care
Administration Office Dr.Saini / Front Desk
Address City, State, 925 Secret River Drive Ste B
Zip Phone 95831

For more information about HIPAA or to file a complaint:

U.S. Department of Human &HealthServices
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Cancellation & No-Show Policy

We appreciate you and understand your time is valuable which is why **we make every effort to keep you from waiting.** As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not cancel with adequate notice or who fail to keep their scheduled appointments. To respect the needs of Orchard Dental Care patients**, if it is necessary to cancel your reserved appointment, we require that you contact our office 48 hours in advance.** Appointments are in high demand, and your early cancellation will give another person the opportunity to access timely dental care. A 'no-show' appointment occurs when a patient misses an appointment without cancelling **48hours in advance.** Missed appointment are an inconvenience to patients who need access to dental care in a timely manner; is inconsiderate to our doctor and team who are left sitting idle. **Last minute/late cancellations are considered 'no- show' appointments.** We reserve the right to charge for any appointment(s) broken without **48 hours' notice.** The charge will be $100 per 1hour of hygiene scheduled and $150 per 1 hour scheduled with the Doctor. **These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment.** Habitual missed/cancelled/rescheduled appointments may result in a patient being required to either pay up front prior to scheduling an appointment for this office may no longer be available to provide dental services for the patient. Our voice mail is available for messages left after business hours, **however if a message is left after business hours cancelling an appointment for the next day this will be subject to our fee.** We understand that extreme/unavoidable emergencies or circumstances do arise which may require you to cancel your appointment, and individual circumstances will be taken into consideration. Our practice firmly believes that good physician/patient relationship is based on trust and good communication. A courtesy call to confirm the appointment is given about a week prior to the appointment date and a courtesy automated text reminders/confirmation are sent to the mobile number provided. Courtesy text reminders and the courtesy call to confirm are a courtesy and may not occur at all. **It is the patient or patients' parent/guardian to remember appointment dates and times after scheduling.** Questions about cancellation and no-show fees should be directed to our Office.

Orchard Dental Care

By signing below, I acknowledge receipt of Orchard Dental Care Cancellation and 'No-Show' Policy.

_____

PRINT NAME OF PATIENT/PARENT/GUARDIAN

_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

_____

DATE