AMARPREET S SAINI, DDS INC.

FAMILY AND COSMETIC DENTISTRY

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?_____ Dental Visit?_____

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

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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	_____
Have you ever taken FOSAMAX, BONIVA, ACTONEL or and other caner medications containing BISPHOSPHONATES?	☐ Yes	☐ No	_____
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

WOMEN, ARE YOU...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ARE YOU ALERGIC TO THE FOLLOWING...

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain _____

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	Drug Addiction ☐ 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 Pace Maker ☐ 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_____

CHANGES IN HEALTH SINCE THE LAST EXAM:_____SIGNATURE OF PATIENT,PARENT or GUARDIAN: _____ DATE:_____

MEDICAL CHANGE REVIEWED BY (DOCTOR)_____ DATE_____

CHANGES IN HEALTH SINCE THE LAST EXAM:_____SIGNATURE OF PATIENT,PARENT or GUARDIAN: _____ DATE:_____

MEDICAL CHANGE REVIEWED BY (DOCTOR)_____ DATE_____

CHANGES IN HEALTH SINCE THE LAST EXAM:_____SIGNATURE OF PATIENT,PARENT or GUARDIAN: _____DATE:_____

MEDICAL CHANGE REVIEWED BY (DOCTOR)_____ DATE_____

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PATIENT INFORMATION *(PLEASE FILL OUT COMPLETELY)*

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

Preferred Name: _____ Patient Is: ☐ Policy Holder ☐ Responsible Party ☐ 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 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 (Please Specify)

_____

_____

_____

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

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

(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:

____ 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:

INSERT YOUR OFFICE NAME|PHONE NUMBER|OFFICE EMAIL ADDRESS:

Patient Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Smile Dental Services & Affiliated Dental Offices respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to 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 information used or disclosed to us in any form, 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, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality 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	Anny Souvannarath
Administration Office	4962 Robert J Mathews Pkwy #200
Address	4962 Robert J Mathews Pkwy #200
City, State, Zip	El Dorado Hills,CA 95762
Phone	(916)542-7316

For more information about HIPAA or to file a complaint:

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