6433 Mission Street | Daly City, CA 94014
Call Today! (650) 353-5969
Visit Us Online: www.PacificSkyDental.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: Male Female

Date of Birth (DOB): _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Can we send text reminders? Yes No

Employer: _____ Occupation: _____

Circle One: Single Married Widowed Divorced Separated Partnered

Spouse's Name: _____

Preferred contact method (please circle):

No Preference Text Email Phone

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

Do you have dental insurance coverage? Yes No

Dental Insurance Co. Name: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Date of Birth: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

I understand that I will be required to pay my ESTIMATED portion of Dr. Raymond Jone's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature: _____

MEDICAL HISTORY

Do you have a physician? Yes No Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: Excellent Good Fair Poor Very Poor

Are you currently under the care/supervision of a physician? Yes No Please Explain: _____

Are you currently taking any prescription medications? Yes No Please List Medications with Correlating Diagnosis: _____

_____

For Women: Are you currently taking any oral contraceptives (birth control pills)? Yes No Are you pregnant? Yes No Are you nursing? Yes No

Do you or have you ever used tobacco in any form? Yes No If yes, how much? _____ For how long? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin •

Please list any other medications and/or materials to which you think you are allergic: _____

Do you Snore? Yes No Are you tired in the day time? Yes No Has anyone observed you stop breathing in your sleep? Yes No

MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? Circle "Yes" or "No."

Abnormal Bleeding	Yes	No	Frequent Headaches	Yes	No	Mitral Valve Prolapse	Yes	No
Alcohol or Drug Abuse	Yes	No	Glaucoma	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Hay Fever	Yes	No	Psychiatric Problems	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Radiation Treatment	Yes	No
Artificial Bones/Joints/Valves	Yes	No	Heart Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Surgery	Yes	No	Seizures	Yes	No
Blood Transfusion	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Cancer/Chemotherapy	Yes	No	Hepatitis	Yes	No	Sickle Cell Disease/Traits	Yes	No
Colitis	Yes	No	Herpes/Fever Blisters	Yes	No	Sinus Problems	Yes	No
Congenital Heart Disease	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	HIV or AIDS	Yes	No	Thyroid Problems	Yes	No
Difficulty Breathing	Yes	No	Hospitalized for Any Reason	Yes	No	(If yes, please explain below.)		
Emphysema	Yes	No	Kidney Problems	Yes	No	Tuberculosis/TB	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Fainting Spells	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No

Please explain any serious medical conditions you have ever had: _____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? Yes No If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? Yes No

Do you have, or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath	Yes	No	Food Collection Between Teeth	Yes	No	Orthodontic Treatment	Yes	No
Bleeding Gums	Yes	No	Foreign Objects in Mouth	Yes	No	Pain Around Ear	Yes	No
Blisters on Lips or in Mouth	Yes	No	Grinding Teeth	Yes	No	Pain When Brushing	Yes	No
Broken Fillings	Yes	No	Gums Swollen or Tender	Yes	No	Periodontal Treatment	Yes	No
Burning Sensation on Tongue	Yes	No	Jaw Pain	Yes	No	Sensitivity to Cold	Yes	No
Chew on Only One Side	Yes	No	Jaw Fatigue	Yes	No	Sensitivity to Heat	Yes	No
Clenching of Teeth	Yes	No	Lip or Cheek Biting	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No	Sensitivity When Chewing	Yes	No
Dry Mouth	Yes	No	Mouth Breathing	Yes	No	Sores or Growths in Mouth	Yes	No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No Do you ever experience pain in your jaw joint (TMJ/TMD)? Yes No

How would you classify your current dental health? Excellent Good Fair Poor Very Poor

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? Yes No Would you like fresher breath? Yes No What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? Yes No On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____ What type of bristles does your toothbrush have? Soft Medium Hard

Pacific Sky Dental

Acknowledgment of Receipt of HIPAA Policies and Procedures

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature:_____

Date:_____

Pacific Sky Dental - Permission to use photographs

I grant Pacific Sky Dental the right to take photographs of me, my smile and my teeth. I, Pacific Sky Dental, may use such photographs for, clinical chart reviews, communication with dental laboratories, communication with other dental specialists and professionals for patient treatment purposes ONLY.

Should I wish to send these photographs to other dental care providers, I shall formally request them in writing as is required by the State Dental Board of California for a transfer of records.

I have read and understand the above:

Print Name: _____

Signature: _____

Date: _____

Pacific Sky Dental

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, 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 11/18/2014, 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 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 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.

Pacific Sky Dental Privacy Official

Telephone: 650-353-5969 **Fax: 650-353-5971**

Address: 6433 Mission Street, Daly City, CA 94014

E-mail: info@pacificskydental.com