Hillview Dental Care

3555Loma Vista #217

Ventura, Ca 93003

NEW PATIENT REGISTRATION		
PATIENT INFORMATION (CONFIDENTIAL)		
Name:		Date:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Check appropriate box: Minor Single Married Divorced Widowed Separated		
If College Student: Fulltime Parttime	Name of School:	
School City:	School State:	
Patient's or Parent/Guardian's Employer:		Work Phone:
Employer's Address:		
City:	State:	ZIP Code:
Spouse or Parent/Guardian's Name:		
Employer:		Work Phone:
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:
RESPONSIBLE PARTY		
Name of person responsible for this account:		Relationship to patient:
Address:		Home phone:
Driver's License #:	Birthdate:	SSN:
Employer:		Work phone:
Is this person current a patient in our office?		
INSURANCE INFORMATION		
Name of insured:		Relationship to patient:
Birthdate:	SSN:	Date employed:
Employer:	Union or Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?

NEW PATIENT REGISTRATION

Do you have any additional insurance? Yes. No. If yes, complete the following:		
ADDITIONAL INSURANCE INFORMATION		
Name of insured:		Relationship to patient:
Birthdate:	SSN:	Date employed:
Employer:	Union for Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?
SIGNATURES		
Signature of patient or parent/guardian if minor.		Date:

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer ({PrivacyOfficerName}):

- 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, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of April, 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. We will post and you may request a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Hillview Dental Care
3555 Loma Vista #217
Ventura, CA 93003
805-643-4184

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

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PATIENT HEALTH HISTORY

PATIENT MEDICAL HISTORY

Name:			Date of Birth:		
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 that you will be receiving. Thank you for answering the following questions.					
	YES	NO		YES	NO
1. Are you in good health?			12. Have you ever taken Fen-Phen/Redux?		
2. Have there been any changes in your general health within the past year?			13. Do you use tobacco?		
3. Date of your last physical exam:			14. Do you or have you used controlled substances?		
4. Physician's Name Address Phone			15. Are you wearing contact lenses?		
5. Are you now under the care of a physician?			16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain.			17. Do you have any disease, condition or problem not listed above that you think I should know about?		
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?					
8. Have you had any abnormal bleeding?			WOMEN ONLY		
9. Do you bruise easily?			18. Are you pregnant or think you may be pregnant?		
10. Have you ever required a blood transfusion?			19. Are you nursing?		
11. Have you had a recent weight loss?			20. Are you taking birth control pills?		
Are you allergic to or have you had any reactions to:					
	YES	NO		YES	NO
Local anesthetics like novocaine			Iodine		
Penicillin or other antibiotics			Any metals (e.g., nickel, mercury, etc.)		
Sulfa drugs			Latex or rubber		
Barbituates, sedatives or sleeping pills			Other (please list)		
Aspirin			Iodine		
Do you have or have you ever had the following:					
	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever			Joint replacement or implant		
Scarlet fever			Stomach ulcer		

PATIENT HEALTH HISTORY

Heart defect or heart murmur			Kidney trouble		
Heart trouble, heart attach, or angina			Tuberculosis		
Chest pain			Persistent cough		
Shortness of breath			Cough that produces blood		
Pacemaker			Chemotherapy (cancer, leukemia)		
Heart surgery			Sexually transmitted disease		
High/low blood pressure			Epilepsy or selzures		
Congenital heart problem			Anemia		
Swelling of feet, ankles, hands			Glaucoma		
Hepatitis, jaundice or liver disease			Nervousness		
Stroke			Tonsillitis		
Sinus trouble			Tumors		
Lung or breathing problems			Mental health care		
Asthma or hay fever			Back problems		
Hives or skin rash			Chemical dependency		
Fainting or dizzy spells			Mitral valve prolapse		
Diabetes			Cortisone treatment		
AIDS or HIV infection			Cold sores/fever blisters		
Thyroid problems			Hypoglycemia		
Allergies			Eating disorders		
Arthritis or Rheumatism					
	YES	NO		YES	NO

PATIENT DENTAL HISTORY

Reason for this visit.	
When was your last dental visit?	
What was done then?	
How often did you visit the dentist before then?	
Previous dentist (name and location).	
Have you had a complete series of dental films (x-rays) taken? When and where?	
How often do you brush your teeth?	
How often do you floss your teeth?	
Is your drinking water fluoridated?	

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?			Do you clench or grind your teeth?		
Are your teeth sensitive to hot or cold liquids/foods?			Do you bit your lips or cheeks frequently?		
Are your teeth sensitive to sweet or sour liquids/foods?			Have you noticed any loosening of your teeth?		
Do you feel pain to any of your teeth?			Does food tend to become caught between your teeth?		

PATIENT HEALTH HISTORY

Do you have any sores or lumps in or near your moth?			Have you ever had periodontal treatment (gums)?		
Have you ever experienced any of the following problems in your jaw?			Ever worn a bite plate or other appliance		
Clicking			Have you ever had any difficult extractions in the past?		
Pain (joint, ear, side of face)			Have you ever had any prolonged bleeding following extractions?		
Difficulty in opening or closing			Do you wear dentures or partials		
Difficulty in chewing			If yes, date of placement		
Do you have frequent headaches			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		

If you could change anything about your smile, what would you change?

SmileChange (Times Roman:9)

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. 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 renedered on my behalf or my dependents.

Signature of patient or parent/guardian if minor.	Date:
Doctor's Comments:	
Signature of doctor.	Date: