J. DANIEL BRIAN, JR., D.D.S., M.S.

ROBERT B. FOLK, D.D.S., M.S.

NEW PATIENT FORM

ACCOUNT INFORMATION

Patient's Full Name _____ Date of Birth _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address _____ City _____ Zip _____

Home Phone_____ Cell Phone_____

Patient's SS# _____ Driver's License #_____

Referred By _____

Employer _____ Phone _____

Work Address_____

Do you prefer to be contacted by e-mail for appointments? YES NO

E-mail_____

RESPONSIBLE PARTY INFORMATION (unless same as above)

Name_____ Date of Birth_____

Address _____ City _____ Zip _____

Home Phone_____ Cell Phone_____

Social Security # _____Driver's License #_____

DENTAL INSURANCE INFORMATION

Patient's relationship to Insured _____ Self _____ Spouse _____ Child

Name of insured_____ Date of Birth_____ SS#_____

Employer_____ Work Phone _____

Address_____ City_____ State_____ Zip_____

Ins. Co._____ Group #_____ ID#_____

Do you have Dual Insurance Coverage? YES NO

By signing this form, I/we authorize the release of information regarding this claim to my insurance carrier or hospitals or other doctors who have treated the patient. I further assign payment directly to this office by signing this form. I acknowledge that I am responsible for all monies due this office not paid by insurance, for the services rendered as described in this/these claim(s). I agree to the office payment / insurance policy. A service charge of 1 1/2 % will be charged on all accounts after 60 days. There is a $25.00 returned check fee.

SIGNED_____ DATE_____

DENTAL HEALTH QUESTIONAIRE

Name_____ Date of Birth_____

Are you currently under the care of a physician?.....YES NO

If YES please describe: _____

Physician's Name: _____ Phone #: _____

History of hospitalization: _____

Allergies, including to latex and medications? _____

Medications presently taking: _____
(including aspirin, etc…) _____

FAMILY HISTORY OF**:** (Circle)		SOCIAL HISTORY: Occupation:_____
Heart Disease	Cancer	Type and frequency of:
Diabetes	Seizures	Tobacco Use:_____
		Alcohol consumption:_____

DO YOU HAVE OR HAVE YOU EVER HAD: *(PLEASE CHECK AT RIGHT OF EACH ITEM)*

(Check each item)	Yes	No	Don't Know	*(Check each item)*	Yes	No	Don't Know	*(Check each item)*	Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or Bleed Easily				Kidney Problems			
Nervousness				Heart Problems or Angina				Venereal Disease			
Stroke				High Blood Pressure				Diabetes			
Glaucoma				Rheumatic Fever				Thyroid Disease			
Cold Sores (Herpes)				Heart Murmur				AIDS/HIV Positive			
Persistent Cough				Mitral Valve Prolapse				Arthritis			
Emphysema				Congenital Heart Lesions				Painful Joints (incl. jaw)			
Tuberculosis/PPD positive				Heart Surgery				Prosthetic Joint(s)			
Asthma				Prosthetic Heart Valve(s)				Hives			
Hay Fever				Pacemaker				Steroid Medication(s)			
Sinus Problems				Blood Transfusion(s)				Drug Addiction			
Anemia				Liver Disease				Alcoholism			
Sickle Cell Disease				Yellow Jaundice				Unexpected Weight Change			
				Hepatitis – Type:				Cancer/Radiation Therapy			

1. Have you ever been told that you should not donate blood? YES NO
2. Females: Are you currently taking Birth Control Pills YES NO
   Are you or might you be pregnant? YES NO Estimate Delivery_____
3. Do you have any disease, condition or problem not listed above?_____
   If yes please describe: _____
   _____

Patient Signature_____ Date:_____

History Review Dates: _____ _____ _____

Summary of pertinent findings/recommended treatment modifications.
Providers signature: Date:

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ENDODONTIC CONSENT AND INFORMATION FORM

Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics, and Medications

We would like our *patients* to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing, sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease) splits or fractures of the teeth, overextension of root canal filling material.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of above minor) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, onlay or filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

_____	_____	_____
DATE	WITNESSED BY:	PATIENT/PARENT SIGNATURE

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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.

THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ***APRIL 14, 2003****, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, your general dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, such as to insurance companies.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer**: KAREY STURM, PATIENT COORDINATOOR**

Telephone: **(858) 487-1559** Fax: **(858) 487-6298** E-mail: **info@bernardoplazaendo.com**

Address**: 11777 Bernardo Plaza Court, Suite 209, San Diego, CA 92128**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

{Please Print}

_____

{Signature}

_____

{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)

_____

_____

_____

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