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# Capistrano Children's Dentistry Patient Information - Adult Form

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Sex:  Male  Female

Occupation: \_\_\_\_\_

Cell Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Work Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Medical Dr. Phone #: (     ) \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Spouse's name: \_\_\_\_\_ Spouse's phone#: (     ) \_\_\_\_\_ - \_\_\_\_\_

**In case of emergency please call:** Name \_\_\_\_\_ phone# (     ) \_\_\_\_\_ - \_\_\_\_\_

Please list names of other family members previously seen in our office: \_\_\_\_\_

How did you hear about us? Whom may we thank for referring you? \_\_\_\_\_

**Email address (for appointment confirmation and updates):** \_\_\_\_\_

Which do you prefer for appointment reminders?  Email  Text  Both

Cell phone # to Text: (     ) \_\_\_\_\_ - \_\_\_\_\_

Ok to leave information about you (medical/dental) or other messages on your cell phone?  Yes  No  
on your home phone?  Yes  No

### Primary Dental Insurance

Insured's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID or Soc Sec #: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co. phone #: \_\_\_\_\_

### Secondary Dental Insurance

Insured's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID or Soc Sec #: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co. phone #: \_\_\_\_\_

### Authorization and Release

I authorize Capistrano Children's Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to me 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 rendered on my behalf or my dependents.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# Capistrano Children's Dentistry

## Adult Health History

Patient's name: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex \_\_\_\_\_

Doctor's telephone #: \_\_\_\_\_

Please circle Yes or No

### Medical History

- 1. Do you have any health problems?..... Y N
- 2. Have you ever had a serious illness or surgery?..... Y N  
If yes, explain: \_\_\_\_\_
- 3. Have you ever been hospitalized?..... Y N
- 4. Date of last physical exam \_\_\_\_\_
- 5. **Do you have (or have you ever had) the following?**
  - Asthma, Hay Fever, Emphysema or Bronchitis..... Y N
  - Persistent cough, coughing blood or Tuberculosis (TB)... Y N
  - Eczema, Hives or skin rash..... Y N
  - Cardiac pacemaker..... Y N
  - Rheumatic heart disease, damaged or artificial heart valve: Y N
  - Heart murmur, congenital heart disease..... Y N
  - Cardiovascular disease (heart defects, heart attack, atherosclerosis, high blood pressure, stroke)..... Y N
  - Arthritis/Inflammatory rheumatism (joints)..... Y N
  - Fainting spells..... Y N
  - Epilepsy or seizures..... Y N
  - Cerebral Palsy..... Y N
  - Hepatitis, jaundice or liver disease..... Y N
  - Diabetes..... Y N
  - Stomach problems, ulcers, hyperacidity..... Y N
  - Kidney problems..... Y N
  - Thyroid problems..... Y N
  - Sickle Cell Disease..... Y N
  - AIDS/HIV..... Y N
  - Immune System disorders..... Y N
  - Venereal Disease, Sexually transmitted disease..... Y N
  - Mental, Emotional or Psychiatric treatment..... Y N
  - Intellectual Developmental Disability..... Y N
  - Developmental or learning disability..... Y N
  - Down Syndrome..... Y N
  - Autism..... Y N
  - Attention Deficit Disorder (ADD or ADHD)..... Y N
  - Vision/Hearing/Speech Impairment..... Y N
- 6. Have you ever had cancer and or surgery, radiation or chemotherapy for a tumor or a growth?..... Y N
- 7. For females, are you pregnant?  
If yes, how many weeks? \_\_\_\_\_ Y N
- 8. Do you have any blood disorders (anemia, abnormal bleeding, etc)?..... Y N
- 9. Have you ever had a blood transfusion?..... Y N

- 10. Do you (did you) drink alcohol, smoke or use tobacco? Y N
- 11. Any disease, condition or problem not listed that you think I should know about? Please list: \_\_\_\_\_ Y N
- 12. Are you taking any of the following medications?
  - Antibiotics or Sulfa Drugs..... Y N
  - Anticoagulants (blood thinners)..... Y N
  - Inhalers, Cortisone or steroids..... Y N
  - For females: Birth Control..... Y N
  - Tranquilizers..... Y N
  - Aspirin..... Y N
  - Dilantin or other anticonvulsant..... Y N
  - Insulin, tolbutamide/orinase..... Y N
  - Any other medications or drugs?..... Y N
  - Please list: \_\_\_\_\_
- 13. Are you allergic or have you had an adverse reaction to:
  - Local anesthetics..... Y N
  - Antibiotics (ie. Penicillin, Sulfa Drugs), Y N
  - Sedatives, Barbiturates..... Y N
  - Aspirin..... Y N
  - Any other allergies? (medicine, foods, latex, etc.)..... Y N
  - If yes, please list: \_\_\_\_\_

### Dental Hx

- 14. Date of last dental exam: \_\_\_\_\_
- 15. How many times a day do you brush? \_\_\_\_\_
- 16. Do you floss? If yes, how often? \_\_\_\_\_ Y N
- 17. Any dental pain in the teeth, gums or mouth?..... Y N
- 18. Have you ever had gum disease / bleeding gums?..... Y N
- 19. Do your parents and relatives have all of their teeth?..... Y N
- 20. Do you grind or clench your teeth?..... Y N
- 21. Do you have any oral habits? Biting nails? Etc?..... Y N
- 22. Do you snore or have sleep apnea?..... Y N
- 23. Do you get frequent headaches or often feel tired?..... Y N
- 24. Have you ever had injuries to your face or mouth?  
If so, when? Explain: \_\_\_\_\_ Y N
- 25. Do you get canker sores or cold sores (fever blisters)? Y N  
If yes, how often? \_\_\_\_\_
- 26. Do you require any special assistance during your dental visits? Please explain: \_\_\_\_\_ Y N
- 27. Have you ever been dissatisfied with past dental treatment? If yes, please explain: \_\_\_\_\_ Y N

To the best of my knowledge, all of the above answers are true.

I understand that it is my responsibility to inform this office of any changes in my medical status.

I authorize the release of any information related to my dental care to other health practitioners and or insurance companies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_

\_\_\_\_\_  
Signature of Dentist

X

X

Capistrano Children's Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: Address: Telephone: Email: Social Security #:

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Anna Chand Telephone: (949) 661-3380 Fax: (949) 661-3339 Address: 31103 Rancho Viejo Rd. Suite D5, San Juan Capistrano, CA 92675

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: Date:

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: Date:

# Capistrano Children's Dentistry

## 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 HEALTH 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 4/14/2003 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 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.

**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, xrays, 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, letters, emails or text).

## **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 \$1.00 for each page, \$20.00 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: Capistrano Children's Dentistry  
Dr. Anna Chand

Telephone: (949) 661-3380  
E-mail: [ccd@childrensdentistry.com](mailto:ccd@childrensdentistry.com)

Address: 31103 Rancho Viejo Rd. Suite D5  
San Juan Capistrano, CA 92675