Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

WELCOME

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Social Security# _____ Drivers License _____ Birthdate _____

E-mail Address _____ Cell Phone _____ Other _____

Preferred Method Of Contact ☐ Office ☐ Phone ☐ Home Phone ☐ E-mail ☐ Other _____

Employed By _____ Occupation _____ Bus. Phone _____

Spouse Name _____ Birthdate _____

Name Of Friend Or Relative To Notify In Case Of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Social Security# _____ Drivers License _____ Birthdate _____

Employed By _____ Occupation _____ Bus. Phone _____

INSURANCE INFORMATION

Do You Or Responsible Party Have Dental Insurance? ☐ Yes ☐ No Secondary Insurance? ☐ Yes ☐ No

If So, Name Of Patient's Insured _____ Employer _____

Social Security # Of Insured _____ Id Number _____

Insurance Company _____ Group Number _____

Ins. Company Address _____

Your Spouse's Social Security # _____ Employer _____

Insurance Company _____ Policy Number _____

Although financial responsibility rests with each patient, we will be happy to submit insurance forms on your behalf.

WHO MAY WE THANK FOR REFERRING YOU TO US

Name _____

CONSENT

This undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

_____ _____

Signature of patient (if minor – parent or legal guardian) Date

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

MEDICAL HISTORY

Patient Name _____ Birth Date _____

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.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____
Have 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 snore? ❑ Yes ❑ No
Have you ever been tested for sleep apnea? ❑ Yes ❑ No If yes, when: _____
Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No
Are you on a special diet? ❑ 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 allergic to any of the following?
❑ Aspirin ❑Penicillin ❑Codeine ❑Local Anesthetics ❑Acrylic ❑Metal ❑Latex ❑Sulfa drugs
❑ 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	Radiation Treatments	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Drug Addiction	❑ Yes ❑ No	Hepatitis B	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Easily Winded	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Excessive Thirst	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Stomach/Intestinal Disease	❑ Yes ❑ No
Breathing Problem	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Cold Sores/Fever Blisters	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
						Yellow Jaundice	❑ Yes ❑ No

Have you ever had any serious illness not listed above? ❑Yes ❑No

Comments: _____

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 _____

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

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

Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

_____

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

PRIVACY PRACTICES

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2009 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information
We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. 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, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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. Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

PRIVACY PRACTICES

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $1.00 for each page, $20 per hour for staff time to 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, costbased 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket 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.

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: 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 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: Dr. Ghandehari
Telephone: (858) 485-1123 Fax: (858) 485-1085
E-mail: rbdentalarts@gmail.com

Address: 16810 Bernardo Center Drive, San Diego, CA 92128

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

PATIENT CONSENT

PATIENT CONSENT FORM FOR USE OR DISCLOSURE OF PATIENT'S PROTECTED HEALTH INFORMATION

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name _____ Date of Birth _____ (for identification purposes)

I hereby authorize Rancho Bernardo Dental Arts to release the following personal health information for: (check all that apply)

- ☐ Dental services claims information
- ☐ Prescription, diagnostic, treatment, and/or care management services
- ☐ Reviews required by HHS or HIPAA-compliant health care operations

The above information may be released by:

- ☐ Phone
- ☐ Fax
- ☐ Mail
- ☐ Friend or Relative
- ☐ Other

My Consent

Effective: Today's Date

I want this consent to:

- ☐ Continue Indefinitely
- ☐ Effective Only Until _____ (date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient _____ Date _____

Or, Personal Representative _____ Date _____

Rancho Bernardo
Dental Arts

16810 Bernardo Center Drive
San Diego, CA 921288
(858) 485-1123

PRIVACY PRACTICES

APPOINTMENT POLICY

Valuable time has been reserved for your dental appointment. A missed appointment results in lost time, which could have been offered to another patient in need of treatment. We make every effort to stay on schedule, so we respectfully ask patients to be prompt and keep their appointments.

Our standard appointment policy is as follows:

If you must cancel your appointment, please call our office at least 24 hours in advance. A 24 hour notice is required to cancel or change an appointment. A $50.00 fee may be charged to your account if the appointment is missed, cancelled or rescheduled without 24 hours of notice.

Broken or Missed Appointments: If two (2) broken/missed appointments occur or two (2) cancellations without a 24-hour notice, our office reserves the right to not schedule subsequent appointments without a deposit.

Exceptions to this policy can be determined only on an individual basis AND according to the circumstances of cancellation. We understand that occasionally, illness or other unexpected emergencies may make it necessary to cancel an appointment with less than 24 hour notice. Please contact our office immediately and we will do our best to accommodate your situation.

I have read, and understood the appointment policy of Rancho Bernardo Dental Arts.

Patient_____ Date_____