PATIENT REGISTRATION

ID:_____ Chart ID: _____

First Name:_____ Last Name:_____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2: _____

City:_____ State:_____ Zip:_____ Pager: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Birth Date:_____ Soc Sec:_____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Hold

Patient Information

Address:_____ Address 2: _____

City: _____ State:_____ Zip:_____ Pager: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date:_____ Age:_____ Soc Sec:_____ Drivers Lic: _____

E-mail:_____ ☐ I would like to receive correspondences via e-mail.

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID:_____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg:_____

Emergency#

_____

_____

_____

_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

Rem. Benefits:_____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

Rem. Benefits:_____ Rem. Deduct: _____

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Date Created: _____

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 talking, could have an important interrelationship with the dentistry you will receive. Thank you fur answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If Yes_____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If Yes_____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If Yes_____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If Yes_____
Do you take, or have you taken, Pnen-Fen or Redux?	☐ Yes	☐ No	If Yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If Yes_____
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	If Yes_____

Women;. Are you …

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penidllin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? _____ ☐ If Yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◎ Yes ◎ No	Cortisone Medicine	◎ Yes ◎ No	Hemophilia	◎ Yes ◎ No	Radiation Treatmerts	◎ 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 or C	◎ 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	Hypoglycema	◎ Yes ◎ No	Sickle Cell Disease	◎ Yes ◎ No
Asthma	◎ Yes ◎ No	Fainting Spells/Dizziness	◎ Yes ◎ No	Irregular Heartbeat	◎ Yes ◎ No	Sinus Trouble	◎ Yes ◎ No
Blood Diseas	◎ Yes ◎ No	Frequent Cough	◎ Yes ◎ No	Kidney Problem	◎ Yes ◎ No	SpinaBiftda	◎ Yes ◎ No
Blood Transfusion	◎ Yes ◎ No	Frequent Diarrhea	◎ Yes ◎ No	Leukemia	◎ Yes ◎ No	Stomach/Intestinal Disease	◎ Yes ◎ No
Breitthing Problems	◎ 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 If Yes _____

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 Guardan:

Protecting Your Confidential Health Information is Important to Us

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Promise

Dear Patient:
This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA - Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who doe not require it. Our office is subject to State and Federal law regarding the confidentiality of your health infoRmation and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health inforn1ation as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official detern1incs that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

How Your HEALTH information May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third pa11ics (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information a required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

+1(209) 951-0673 office@garyhsakai.com www.garyhsakai.com

NOTICE OF PRIVACY PRACTICES

To The U.S. Department of Health and Human Services (HHS)
We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are scaled. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach
You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice
We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the tern1s of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

Patient Signature: _____ Date: _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

OFFICE GUIDELINES

Our philosophy is to provide the highest quality of patient education and dental care to all patients that choose us for their dental care. Our hope is by providing you the following information we can prevent misunderstandings to ensure you encounter a positive experience. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you opportunity to plan for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want. It is necessary to provide accurate insurance information so estimates can be as accurate as possible.

_____ Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you be familiar with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45-days. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite the processing of your claim. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_____ Initials

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

☐ Cash/Check ☐ MasterCard ☐ Visa ☐ Other _____ ☐ Extended Payment _____(Please see below)

Please Note: A $25.00 NSF fee will be charged fora II returned checks. If you desire a monthly payment plan, we invite yo11 to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90-days may be subject to a rebilling fee.

_____ Initials

CANCELLATIONS

We consider all appointments confirmed when they are reserved. We do not double book with anticipation of patients not showing for their needed dental care. Our schedule remains open yet, fully staffed when patients cancel or fail the same day of their appointment. We require advance courtesy notice of 2-business days. This time allows us opportunity to reappoint a more convenient time for you and it gives us time to offer your appointment to another patient.

_____ Initials

CELLPHONES

We ask that cell phones and pagers be turned off at all times while in the treatment area. If being available for an emergency during your reserved appointment is necessary, please leave our office telephone number so you can be reached. If an unfortunate emergency arises, we will notify you in the treatment area immediately.

_____ Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

Thank you for Understanding of the Office Guidelines!

My signature indicates that I understand the policies as outlined and any questions J have with regard to office policies have been answered.

Signature of Responsible Party or Patient _____ Date _____

My signature indicates that J have reviewed the office policies with the responsible party and/or patient.

Signature of Staff Member or Doctor _____ Date _____