WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

six 6

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

NELSON Y. HOWARD, D.D.S.
Dental Artistry and Aesthetic Enhancements

Accredited Member, American Academy of Cosmetic Dentistry

TELL US ABOUT YOUR SMILE

Are you happy with your smile and the appearance of your teeth? ____ Yes ____ No

If not, what don't you like about your smile and/or your teeth? _____
_____
_____

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to see? _____
_____
_____

If you could easily and safely whiten your teeth, would you be interested? ___ Yes ___No

Do you have crowns or fillings on your front teeth? ___ Yes ___ No
Do you like the way they look? ___ Yes ___ No
Do they look natural to you? ___ Yes ___ No
Do they look like your normal teeth used to look? ___ Yes ___ No
Are they the same color as your other surrounding teeth? ___ Yes ___ No

Have you ever heard of Veneers and how they can improve your smile? ___ Yes ___ No
Are you aware that they can also protect and strengthen your teeth? ___ Yes ___ No
Would you like to know how they could enhance and improve your smile? ___ Yes ___ No

Do you have silver fillings in your teeth? ___ Yes ___ No
Do you like them? ___Yes ___ No
Are you aware that they can easily be changed and the new fillings can actually strengthen and prevent your teeth from cracking? ___ Yes ___ No
Have you ever thought about changing them to look more like natural teeth? ___Yes ___No

Do you have any other concerns about your smile or your teeth? _____
_____
_____
_____
_____

Dedicated to Excellence and the Finest Quality of Care

Nelson Y. Howard, D.D.S., Inc.
1903 W. San Marcos Blvd., Suite 110 • San Marcos, California 92078
Office: (760) 599-6559 Fax: (760) 599-6599
www.nyhowarddds.com

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HELPFUL INFORMATION REGARDING YOUR DENTAL INSURANCE.....

Q: MY DENTAL INSURANCE TAKES CARE OF THIS, DOESN'T IT?
A: Please realize professional services are rendered to a person, and not to an insurance company; thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We are unable to render service on the assumption the charges will be paid entirely by your insurance carrier. We will help in every way we can in filing your claim and handling inquiries from our office on your behalf. We are, in fact, anxious to help you realize all you possibly can from your carrier.

Q: MY INSURANCE COVERS 100%, DOESN'T IT?
A: Insurance companies determine the amount to be paid by using a predetermined "Schedule of Allowances". They will then pay a percentage (40% to sometimes 100%) of allowance and NOT the doctor's usual and customary fee. Therefore we will use our experience to estimate your portion and make financial arrangements with you accordingly. Please realize that we cannot guarantee you this exact estimated figure as payment in full.

Q: CAN YOU FILL OUT MY INSURANCE FORMS FOR ME?
A: We will be happy to complete Doctor's portion of the claim form and request that you complete all your personal information and sign where requested before leaving your form with us. It is most helpful to have your form and insurance ID card on your first visit. If you cannot obtain a form in time, as a convenience for our patients we have standard claim forms most companies accept.

Q: WILL I EVER HAVE TO DEAL DIRECTLY WITH MY CARRIER?
A: Yes, on two occasions. First, should you have any questions about the benefits they provide; these questions should be directed to your carrier personally or perhaps someone in your personnel office could be of help to you. Second, if you have treatment done we would appreciate your payment in full, and in turn provide you with a "Superbill" complete and ready to attach to your claim form. All you need to do is complete your personal information and sign the form. We will keep a copy on file in case your carrier has any questions.

Q: WILL I STILL GET A MONTHLY BILLING STATEMENT?
A: Monthly statements will be sent to you showing your entire balance less your applied payments as received. The statement will also reflect when we bill your carrier and when payment is received. Please refer to your agreed upon financial arrangement for your estimated share.

Q: CAN YOU BILL ME AFTER THE INSURANCE CARRIER PAYS?
A: Since insurance companies take up to sixty or ninety days to process their claims, a large portion of your total fee is deferred. Therefore, your payment is required as services are rendered to meet current expenses unless otherwise pre-arranged.

By signing below, I am indicating that I have read the above information regarding my dental insurance and understand it's contents. I am also aware that I am ultimately responsible for my account, regardless of my insurance benefits, and agree to pay Dr. Howard any unpaid balance upon completion of treatment rendered.

_____ _____

Signature of patient/guardian Date

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Important Patient Information:

The following is our office policy information and is provided for your understanding. We feel the more you know about our policies and methods of practice the more we can be of service to you and avoid possible frustrations and misunderstandings.

When we schedule an appointment please understand we design our schedule to offer individualized quality care for you. We require 48 hours (two working days) notice to change an appointment. This advanced notice allows us to offer this valuable time to another patient who is in need of treatment. We realize and understand that sometimes circumstances prevent our patients from keeping their appointment. Regretfully, if you cancel or change your appointment with less than 48 hours notice or you do not show at all we reserve the right to bill you the entire amount of the procedure(s) you were scheduled for with either our dental hygienist or Dr. Howard.

Please note all situations will be reviewed by Dr. Howard prior to a final billing determination.

_____ _____

I have read and agree to the above information *Date*

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Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist for input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is: Federal Office Building, 50 United Nations Plaza – Room 322, San Francisco, CA 94102.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: January 1st, 2003

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date