About You

Today's Date: _____

Name:_____

Preferred Name:_____

Birthday:_____**Age:**_____

Social Security #:_____

Home Address:_____

_____

Spouse's Name:_____

Spouse's Birthday:_____

Child's Name:_____

Child's Birthday:_____

Child's Name:_____

Child's Birthday:_____

Employer:_____

Occupation:_____

Hobbies/Interest:_____

Other family members seen by us:_____

Person Responsible for account:_____

Relation:_____

Whom may we thank for referring you?_____

Contact

We like to make reminder calls to you, please make sure we have a home, work and/or cell phone number.

Home #:_____

Cell #:_____

Work: # :_____

Email Address:_____

Please circle one of the follow as your preferred method of contact: Home# Cell# Work#

Emergency Contact:

Name:_____

Relationship:_____

Phone Number #:_____

Address:_____

Insurance Benefits

Dental Coverage? □Yes □No

Insured Name:_____

Insured Birthdate:_____

Insured ID/SS#:_____

Insurance Company Name:_____

Insurance Phone Number:_____

Primary Subscriber's Name(if patient above is not the main subscriber): _____

Group #:_____

Subscriber/ Member ID #:_____

If you have a secondary insurance, please let us know.

"Be generous of your time with your patients."

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment, or any dental treatment performed without prior financial arrangements will be paid for at the time of treatment is performed. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all dental treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 90 days. I grant my permission to your office to telephone me at home or my work to discuss matters related to this form of my dental treatment. I realize that appointment times are reserved and that if I fail to give at least 48 hours' notice, I may be charged a fee. If my account should be sent to a collection agency, I will be responsible for my insurance be billed by this office, I authorize the Dentist(s) and/or the staff to furnish information to the insurance carrier necessary to complete and/or settle my dental claim. To the best of my knowledge, the above statements on this form are true and complete.

PLEASE INQUIRE ABOUT ANY QUESTIONS WHICH ARE NOT UNDERSTOOD I CONSENT OF TREATMENT

I do authorize and give consent to administer treatment, including but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I further state that the medical and dental history was completed, fully and accurately to the best of my knowledge.

_____ _____

PATIENTS OR REPOSIBLE PARTY'S SIGNATURE **DATE**

Medical History

Name:_____ Birthday:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your body. Health problems that you may have or medication(s) that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	If yes, please explain:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken Phen-Fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances, herbal supplements or medication?			
Do you have a medical condition that requires you to pre-medicate with antibiotics before dental treatments?			

Preferred Pharmacy (Name & Location EX: CVS Rancho Bernardo) _____

Medication Name (Please list ALL medication you are currently on including injections)	**Medication Type (Please select one of the following)**	**Dose / How many I take in each day?**	**Why am I taking this Medication?**	**Date Prescribed**
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			

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 the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Do you have, or have you ever had any of the following? Please check all that apply.

☐	AIDS/ HIV Positive	☐	Chest Pains	☐	Frequent Headaches	☐	Irregular Heartbeat	☐	Scarlet Fever
☐	Alzheimer's Disease	☐	Cold Sores/ Fever Blister	☐	Herpes	☐	Kidney Problems	☐	Shingles
☐	Anaphylaxis	☐	Congenital Heart Disorder	☐	Glaucoma	☐	Leukemia	☐	Sickle Cell Disease
☐	Anemia	☐	Convulsions	☐	Hay Fever	☐	Liver Disease	☐	Sinus Trouble
☐	Angina	☐	Cortisone Medicine	☐	Heart Attack/ Failure	☐	Low Blood Pressure	☐	Spinal Bifida
☐	Arthritis/Gout	☐	Diabetes	☐	Heart Murmur	☐	Lung Disease	☐	Stomach/ Intestinal Disease
☐	Artificial Heart Valve	☐	Drug Addiction	☐	Heart Pace Maker	☐	Mitral Valve Prolapse	☐	Stroke
☐	Artificial Joint	☐	Easily Winded	☐	Heart Trouble/Disease	☐	Pain in Jaw Joints	☐	Swelling of Limbs
☐	Asthma	☐	Emphysema	☐	Hemophilia	☐	Parathyroid Disease	☐	Thyroid Disease
☐	Blood Disease	☐	Epilepsy or Seizures	☐	Hepatitis A	☐	Psychiatric Care	☐	Tonsillitis
☐	Blood Transfusion	☐	Excessive Bleeding	☐	Hepatitis B or C	☐	Radiation Treatment	☐	Tuberculosis
☐	Breathing Problem	☐	Excessive Thirst	☐	Herpes	☐	Recent Weight Loss	☐	Tumors or Growths
☐	Bruise Easily	☐	Fainting Spells/Dizziness	☐	High Blood Pressure	☐	Renal Dialysis	☐	Ulcers
☐	Cancer	☐	Frequent Cough	☐	Hives or Rash	☐	Rheumatic Fever	☐	Venereal Disease
☐	Chemotherapy	☐	Frequent Diarrhea	☐	Hypoglycemia	☐	Rheumatism	☐	Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain: _____

_____

Women: Are you…

☐Pregnant/Trying to get pregnant?

☐Nursing?

☐Taking oral contraceptives?

☐Is there any chance you may be pregnant?

Are you allergic to the following?

☐Aspirin

☐Penicillin

☐Codeine

☐Acrylic

☐Metal

☐Latex

☐Local Anesthetics

☐Other If yes, please explain:

_____

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 the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Dental Information

Name of Previous Dentist:_____

Phone:_____City/ State:_____

How long has it been since your last dental visit?_____ What kind of treatment was done?_____

Does dental treatment make you nervous? YES NO

Are you in pain at this time? YES NO If yes, Where?_____

Do you have any discomforts caused by hot or cold liquids, or sweets?_____

Have you ever had periodontal treatment? YES NO If yes, when?_____

Is there a tendency for dental problems in your family? YES NO If yes, please explain?_____

Does you jaw feel tired or ache? YES NO Do you clench or grind your teeth? YES NO

Do you bite your fingernails, pencils, bobby pins, thread, etc.?_____

Are you happy with the appearance of your teeth?_____

Why do you seek dental care at this time?_____

Have you ever had problems with:

Local Anesthetics? YES NO If yes, please explain?_____

Previous dental treatment? YES NO If yes, please explain?_____

Nitrous Oxide (laughing gas)? YES NO If yes, please explain?_____

What can we do to make your visits more comfortable?_____

Any additional comments?_____

Is there anything about your health history that you have not told us about?_____

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 the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Patient HIPPA consent form

I understand that have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing the consent I authorize you to use and disclose my protected information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

- Obtaining payment from third party payer (e.g. my insurance company)

- The day-to-day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time, However, any use or disclosure that occurred prior to the day I revoked this consent is not affected.

Print Patient Name:_____ Date:_____

Signature:_____ Relationship to Patient:_____

NOTICE OF PRIVACY PRACTICES

(Dental)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

● Treatment means providing, coordinating or managing health care and related services b one or more health care providers. An example of this would include teeth cleaning services.

● Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this of this would be sending a bill to your visit to your insurance company for payment.

● Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions to the Privacy Officer.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

● The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. lf we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

● The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

● The right to inspect and copy your protected health information.

● The right to amend your protected health information.

● The right to receive an accounting of disclosures for protected health information.

● The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with the respect to protected health information.

This notice is effective as of January 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA, or to file to file a complaint, please contact:

The U.S Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W, Washington, D,C. 20201
(202)619-0257 or Toll Free: 1-877-696-6775

Insurance and Patient Responsibility

Dear Patient,

At our office, we strive to offer the best care and service possible, and part of that involves helping you understand how your insurance may impact the cost of your treatment. Please be aware that the estimate we provide is based on the information we have received from your insurance company and reflects an approximate percentage of coverage.

While we make every effort to assist you in maximizing your insurance benefits, it is essential to understand that this estimate is not a guarantee of coverage. Insurance plans vary greatly, and it is your responsibility to familiarize yourself with the specific terms and conditions of your insurance policy. This includes understanding details such as coverage limits, frequency of treatments, and any potential exclusions or limitations.
To assist you, our office will file your insurance claims as a courtesy. However, please note that the final determination of coverage and payment is made by your insurance company, not by our office. If there are any discrepancies or if the insurance company denies or adjusts the claim, you will be responsible for any remaining balance.

We encourage you to contact your insurance provider directly if you have any questions about your coverage or if you need clarification on your benefits. Your understanding of your policy will help ensure a smoother process and help you avoid unexpected costs.

Payment for all services are due at the time of treatment. We will still give you an ESTIMATE of what we believe your insurance will contribute for the services provided. Your insurance will then reimburse you directly to the address on file.

If you have any questions about your treatment estimate or need assistance with insurance matters, please don't hesitate to reach out to our office. We're here to help and want to make sure you have all the information you need to make informed decisions about your dental care.

Important Reminder About Insurance Changes:
If there are any changes to your insurance coverage or if you switch to a new plan, it is crucial that you inform our office as soon as possible. We are not able to track or verify changes in your insurance plan on your behalf. Timely notification ensures that we can update our records and provide the most accurate estimates and billing information.

I certify that the information I have provided regarding my insurance coverage is correct and authorize Dr. James Spalenka office to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I agree to pay any payments, copayments or deductibles as required by my insurance plan for dental care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Signature:_____

Date:_____

What are intraoral images?

An intraoral image is defined as a photographic image/images obtained by intraoral or extra oral cameras; these full mouth diagnostic photos are deemed necessary to document diagnosis.

Why do we take them?

lntra oral images are important diagnostic aids for our dentists and professional staff. By taking these images our professionals are able to map out a clear plan and assessment of the patients' needs as well as being able to clearly envision how to correct a problem. lt magnifies the image, enables us to detect lesions, assists the dentists in restoring the tooth's anatomy and, it depicts the severity of the tooth conditions.

These images are also beneficial when it comes to instance filing. At times, x-rays do not support our clinical observations. The images allow us to show insurance companies what we see. Diagnostic photographs provide accurate documentation of the tooth's preoperative condition. Documentation is needed to monitor treatment progress for possible questions by a third-party oater, your insurance.

Photos

I authorize the dentist and his team to take photographs, intraoral slides of my teeth. I understand that the photographs will be used as a record of my care.

Patient Name:_____

Signature:_____ **Date:**_____

Consent for Audio Recording

We care about your care! Our practice utilizes technology designed to record and capture key details of our conversation and the care provided. This system allows us to focus entirely on you by reducing the need for manual note-taking. By streamlining documentation, this technology helps us deliver a higher level of care. Your privacy is extremely important to us. All information recorded is used solely to support your treatment and is accessible only to authorized healthcare professionals involved in your care. Our practice follows strict privacy and security standards to protect your health information. By signing below, you acknowledge and agree to the use of this technology for documentation purposes during your appointment.

□ I acknowledge and consent to the use of technology for documenting clinical details during my visit. I understand that this helps support my care and that my information will remain secure.

□ I decline the use of voice recording

Signature:_____Date:_____