DATE:		

Welcome Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care.

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Patient Informatio	n (CONFIDENTIAL)		Cell Phone
Name	Birth Bert Bert	hdate	
	City		
Check Appropriate Box Minor			☐ Widowed ☐ Separa
Patient's or Parent's Employer			
Business Address			
Spouse or Parent's Name	Employer		Work Phone
If Patient is a Student, Name of School / Colle			
Whom May We Thank for Referring You? _			
Person to Contact in Case of Emergency			
Responsible Party Name of Person Responsible for this Account Address			
Driver's License #	Birthdate	Financial Institution	
Employer			Work Phone
Is this Person Currently a Patient in our Office			*
Insurance Informa	tion		Relationship
Name of Insured			Relationship to Patient
BirthdateSoci	ial Security #		Date Employed
Name of Employer			Work Phone
Address of Employer	City		State Zip
bisurance Company	(im	up #	Union or Local #
Ins. Co. Address	City		State Zip
How Much is your Deductible?	How Much Have You Used?	м	ax Annual Benefit
DO YOU HAVE ANY ADDITIONAL INS	URANCE? Yes No	IF YES, COMPL	ETE THE FOLLOWING:
Name of Insured			Relationship to Patient
BirthdateSoci	ial Security #		Date Employed
Name of Employer			Work Phone
Address of Employer			
Insurance Company			Union or Local #
Ins. Co. Address	City		State Zip
How Much is your Deductible?	How Much Have You Used	?M	ax. Annual Benefit

Patient Medical History

Physician	Office Phone		Date of Last Exam		
	Yes	No		Yes	No
1. Are you under medical treatment now?			7: Are you allergic to or have you had any reactions to the followine?		П
Have you ever been hospitalized for any surgical operation or serious illness?			to the following?	Ħ	P
3. Are you taking any medication(s)		_	Penicillin please specify other antibiotics	H	H
including non-prescription medicine?	Ц	П	Barbinates	Ħ	Ħ
If yes, what medication(s) are you taking?			Sedatives	ш	
4. Do you use tobacco?			lodine	H	H
5. Do you use alcohol, cocaine or other drugs?			Other (Please Specify)		
6. Are you wearing contact lenses?			8. Women Only:		
			a) Are you pregnant or think you may be pregnant?		
			b) Are you nursing? c) Are you taking birth control pills?		
			c) Are you taking birth: control pills?		П
9. Do you have or have you had any of the following:	,				
High Blood Pressure	11 Di		Yes No	Yes	No
Heart Attack	Heart Disease Cardiac Pacemak Heart Murmur		Chest Pains	H	H
Rheumatic Fever	Heart Murmur	æ1	Stroke	Ħ	
Swollen Ankles	Angina			Ħ	
	Frequently Tired		Tuberculosis	Ħ	
Fainting / Seizures	Anemia		Radiation Therapy	ō	ō
Low Blood Pressure	Emphysema		Glaucomc		
Epilepsy / Convulsions	Emphysema		Recent Weight Loss	\Box	
Leukemia	Arthritis		Liver Disease	ш	
Diabetes	Joint Replacement	or bry	plant Heart Trouble	ш	
Kidney Diseases 🔲 📗	Hepatitis / Journali	œ	L L Respiratory Problems	H	
AIDS or HIV Infection	Sexually Transmi	ned Di	sease Other	П	П
Thyroid Problem	Stomach Troubles	:/Ulce	<u> </u>		
Patient Dental History	<i>y</i>			V	NI.
1. Do your gums bleed while brushing or flossing? 2. Are your teeth sersitive to hot or cold liquids/foods:	ř	No	© Daniel have français handarher?	ñ	ñ
2. Are your teeth sersitive to hot or cold liquids foods:	, H	d	9. Do you deach or grind your teeth?	Ħ	Ħ
3. Are your teeth sensitive to sweet or sour liquids/foo	4c2	Ħ	8. Do you have frequent headaches? 9. Do you clench or grind your teeth? 10. Do you bite your lips or checks frequently?	$\overline{\Box}$	靣
4. Do you feel pain to any of your teeth?		Ħ	11. Have you ever had any difficult extractions		_
5. Do you have any sores or lumps in or near your me	nath?	Ħ	in the past?		
6. Have you had any head, neck or jaw injuries?			12. Have you had any orthodontic work?		
7. Have you ever experienced any of the following	- 1 -		13. Have you ever had any prolonged bleeding	_	_
problems in your jaw?	1.0	- Si	following extractions?	П	П
a) Clicking?			14. Have you ever had instruction on the correct		
b) Pain (joint, ear, side of face)?			method of brushing your teeth?	Ц	П
c) Difficulty in opening or closing?	Ц	H	15. Have you ever had instructions on the care	П	
d) Difficulty in chewing?	U	П	of your gums?	_	
Authorization and Rei	loge				
			5 vii 2 s 2 s 2 s 2 s 2 s 2 s 2 s 2 s 2 s 2		
I certify that I have read and understand the above	information to the	best o	my knowledge. The above questions have been accurately of	enswe whine	red.
Landovermed that remaining incorrect information a	one he domorrous	O MEN !	nealth. I authorize the dentist to release any information includer my child during the period of such Dental care to third party.	- P	
and/or booth practitioners (authorize and reques	T WAY INCLUMENCE CO	WITH STITLE	to pay arrestly to the dentist of dential group bising with	,	
otherwise payable to me. I understand that my den	tal insurance carr	ier ma	y pay less than the actual bill for services. I agree to be respo	MSIDIC	
for payment of all services rendered on my behalf of	n my aepenaents.				
X					-
Signature of patient or parent if minor		-	1		
Doctor's Comments					
	Signature		Date		

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") 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. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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 by 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 would be sending a bill for 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 relying on your authorization.

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 disclosures 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. If 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 of 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 to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of Apail 19, 2003 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 provisions 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.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

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

form #2

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name	
Relationship to Patient:	
Signature:	
Date	

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Burton M. Ogata DMD

SIGNATURE ON FILE

- 1. I hereby authorize payment of my dental insurance benefits to Burton M. Ogata DMD. I understand I am financially responsible for any charges whether or not paid by my insurance company.
- 2. If my insurance company designates co-payments and/or deductibles, I agree to pay them to Burton M. Ogata DMD.
- 3. I authorize Burton M. Ogata DMD to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.
- 4. I understand that, by signing this Consent form, I am giving my consent to your use & disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name	
Relationship to Patient:	
Signature	
Date	