

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive (check one or both) Appointment Reminders Practice Newsletter

What is your preferred method of contact? Home Phone Work Phone Mobile Phone E-Mail

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Sex Male Female Marital Status Married Single Divorced Separated Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a Minor? Yes No Full-time Student Yes No Name of School _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ Relationship to Patient Self Spouse Parent Other _____

If patient is a Minor, primary residency Both Parents Mom Dad Step Parent Shared Custody Guardian

Address: (if different from patient) Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer (if different from above) _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Medical Plan Information

Plan Name _____ Phone _____
Address: Street _____ City _____ State _____ Zip _____
Name of Insured _____ Date of Birth _____ ID Number _____
Policy Number _____ Patient Relationship to Insured _____ Deductible Amount _____

Whom may we thank for referring you?

- One of our valued patients (*name of patient*) _____
 Advertisement _____ Local Dental Society _____
 Our Website Other _____

Please list other members of your immediate family who are patients in our practice

Dental Treatment: The undersigned hereby authorizes the doctor or designated staff member to take x-rays, study models, photographs or any other diagnostic records to make a thorough diagnosis. I authorize the doctor to perform all recommended treatment mutually agreed upon for my child or myself and to use the appropriate medication therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept cash, check or VISA/MasterCard payment. If financial arrangements have been made in advance and payments are not received by the agreed upon date, I accept that a 1-1/2% finance charge (18%APR) will be added to my account. I authorize King St. Dental to accept credit card payments over the telephone. I agree to pay all credit card charges in accordance with the card issuer agreement.

** Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your dental benefit plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan, you are responsible for payment in full.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$50 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$50 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and I consent to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of all information and/or records to: 1) insurance company or their representative 2) another dental office 3) dental laboratory. _____ (initial)

I authorize King St. Dental to receive the assignment of benefits from my insurance company for services rendered. _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices and Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature (Patient or Representative) _____ Date _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No **Is your general health good?**
If NO, explain _____
2. Yes / No **Has there been a change in your health within the last year?**
If YES, explain _____
3. Yes / No **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
If YES, explain _____
4. Yes / No **Are you being treated by a physician now?**
If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes / No **Have you had problems with prior dental treatment?**
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes / No **Are you in pain now?**
If YES, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No Cosmetic surgery | Yes / No Eating disorders |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| | | Yes / No Tuberculosis |

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- | | | |
|--|-----------------------|------------------------|
| Yes / No Aspirin | Yes / No Valium | Yes / No Tetracycline |
| Yes / No Darvon | Yes / No Demerol | Yes / No Vicodin |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Percodan |
| Yes / No Latex | Yes / No Food | Yes / No Nitrous oxide |
| Yes / No Local anesthetic
(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal |

Others _____

Dental Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) _____

Former Dentist _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? Yes No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? Yes No

If yes, why? _____

Have you been anxious about having dental treatment? Yes No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite | <input type="checkbox"/> Food gets caught in between teeth |
| <input type="checkbox"/> Discolored teeth | <input type="checkbox"/> Underbite | If yes, where? _____ |
| <input type="checkbox"/> Crowding/Crooked teeth | <input type="checkbox"/> Uncomfortable bite | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Old fillings (gold or silver) | If yes, where? _____ |
| <input type="checkbox"/> Spaces in between teeth | <input type="checkbox"/> Old crowns | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Loose tooth/teeth | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tooth shape or size | <input type="checkbox"/> Too much gum tissue when I smile | |

Have you ever had orthodontic treatment? Yes No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? Yes No

If yes, when? _____

Have you whitened your teeth in the past? Yes No

If yes, what method? _____

Are you interested in learning more about the following? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening | <input type="checkbox"/> Tooth-colored fillings | <input type="checkbox"/> At-home oral hygiene care |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Periodontal treatment during pregnancy |
| <input type="checkbox"/> Veneers | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |



HIPAA: NOTICE OF PRIVACY PRACTICES

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws 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 April 14, 2003, 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 that 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 protected health information that we maintain, including dental/medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that maybe made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other healthcare providers who may be treating you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another dentists or health care provider (e.g., a specialist or laboratory) who, at therequest of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your dentist.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected 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. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, e-mail, or text message).

Electronic Communication: We may use or disclose your health information to provide you with emails (i.e. e-mail correspondence). Your email address is protected by this office. We will not sell or share your email address with anyone.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to

the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$25.00 to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected 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.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. 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 protect the privacy of your protected health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Name of Contact Person:

Juliette Russell, KING STREET DENTAL

Telephone: 415.347.3817

Fax: 888.343.3817

Email: getperfectsmile@kingstdental.com

Address: 170 King Street, Suite 105

San Francisco, CA 94107



HIPAA: PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. **You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of King Street Dental's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

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

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

Three horizontal lines for additional notes or comments.