PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Preferred Name_____ Drivers License No. _____ Email _____ Phone No. _____

Street _____ Apt # _____ City _____ State _____ Zip _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

Former Dentist _____ Date of Last Dental X-Ray _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

Street _____ Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

EMAIL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT_____

EMPLOYER _____ OCCUPATION _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE

EMPLOYER _____ OCCUPATION _____(____)_
NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP_____

ADDRESS _____ CITY, STATE_____

HOME PH. _____ CELL PH. _____

WORH PH. _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name _____

Insurance Co. _____

E-MAIL _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

Policy No. _____ Effective Date _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name _____

Insurance Co._____

E-MAIL _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

Policy No. _____ Effective Date _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Mona Kaur, DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dental office may use my health care information and disclose such information to the above named insurance company(ies), and for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____

Signature of patient, parent, guardian, or personal representative **Date**

_____

Please print name Relationship to patient

HEALTH HISTORY

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist?

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial Heart Valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotheropy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons,
Nitrous Oxide	Codeine	Penicillin	gloves, etc.)

Are you aware of being allergic to any other medications or substances?
If yes, list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Smile32 Family Dentistry

Financial Policies

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. Please feel free to ask us about any questions or concerns you may have. Thank you!

- Insurance**:** At Smile32 Family Dentistry, we are happy to bill both primary and secondary insurances for you. We feel it is important to explain, however, that **insurance companies cannot guarantee dental benefits to us, and all estimates for your portion due are truly only an estimate.** It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement. Insurance is never a guarantee of coverage. I understand that **posterior restorations are often paid with an "alternate benefit"**, and I will be responsible for the difference.

- Patient Payment: The **patient portion due for services rendered is expected at the time of service** unless *previous* arrangements have been made with the office. We accept cash, checks, and all major credit cards.

- Financing**:** We have financing available through Care Credit. If you have an interest in this option, please consult with the office prior to the date of scheduled treatment.

- Refunds for Unfinished Treatment**:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office.

- Credits on an Account**:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- Collections**:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding. I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Dr. Mona Kaur's staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

Patient Name:_____ Date:_____

Financially Responsible Person:_____

Signature of Financially Responsible Person: _____

Smile32 Family Dentistry

Appointment Policy

We respect that your time is valuable; therefore we make every effort to see our patients at their scheduled time. As a courtesy to our staff and other patients, if you are 15 minutes late for your scheduled appointment, we may need to reschedule you for another date and time.

We request notice to cancel or **reschedule an appointment at least 48 hours in advance**.

An Appointment that is cancelled with less than 24 hours notice is considered a Missed Appointment and may be subject to a cancellation fee.

Our policy is to charge $25 per 30 minutes of schedule time for missed appointments.

Any Missed Appointment charge must be taken care of before rescheduling another appointment.

I have read and understand the appointment policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____

Signature of Patient (or guardian) Date

_____

Name of Patient (print)

Smile32 Family Dentistry

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided 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 health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our 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 HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 *$2.00* for each page, *$25.00* per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your 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.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive 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.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

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 the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U S Department of Health and Human Services.

Contact: Office Manager
Telephone: 650.575.8152
Email: Office@smile32familydentistry.com
Address: 2211 Parkside Dr. Suite D,
Fremont, CA, 94536

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read and understand this office's Notice of Privacy Practices.

Explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regard to my protected health information
- The office obligations concerning the use and disclose of my protected health information

I understand that the nature of privacy practices may be revised from time to time, and that I am entitled to receive a copy of any revised notice of my privacy practice upon request.

_____
{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)

_____

_____

_____