1600 Webster Street Ste. C, San Francisco CA 94115
Tel: (415) 500-2116

New Patient Form

Patient information:

First name_____preferred name_____date of birth_____
Last name_____male/female_____social security#_____
Address_____marital status_____
City_____State_____Zip_____Home phone_____
Cell _____ Email _____
In case of emergency whom may we contact?_____Phone_____

Insurance information

Insured person's name_____date of birth_____
Social security#_____relation to the patient_____
Name of insurance_____insurance phone#_____
City_____state_____zip_____policy or group#_____
Insured person's employer_____
Employer phone _____

Secondary insurance information

Insured person's name_____relation to the patient_____
Date of birth_____social security#_____
Name of insurance_____insurance phone#_____
City_____state_____zip_____policy or group#_____

HOW DID YOU FIND OUT ABOUT US?_____

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and /or Guardian to be necessary or advisable, including the use of local and/or general anesthesia and other medications as indicated. I am responsible for payment of services rendered.

Patient signature_____**date**_____

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Medical History

Name:_____

General information

Yes___no____is your health good?_____
Yes___no____has there been a change within three years? If yes please explain_____
_____
Date of last dental exam?_____
Last time when you had your dental x-rays taken?_____
Have you had any complications with your previous dental treatment?_____
If yes, please explain _____
Is there anything that you want us to do to make you more comfortable?_____
If yes, please tell us_____

Have you experienced any of the following?

Yes	no	chest pain	yes	no	dizziness
Yes	no	swollen ankles	yes	no	headaches
Yes	no	shortness of breath	yes	no	ringing in ears
Yes	no	joint pain, TMJ syndrome	yes	no	fainting spells
Yes	no	persistent coughs	yes	no	seizures
Yes	no	bleeding problems, bruising	yes	no	excessive thirst
Yes	no	sinus problems	yes	no	dry mouth
Yes	no	frequent vomiting			

Do you have or had any of the following?

Yes	no	heart disease	yes	no	VD(syphilis,gonorrhea)
Yes	no	heart attacks, heart defects	yes	no	AIDS or HIV+
Yes	no	heart murmurs	yes	no	eye diseases
Yes	no	prosthetic heart valve	yes	no	blood disorder
Yes	no	pacemaker	yes	no	anemia
Yes	no	rheumatic fever	yes	no	skin diseases
Yes	no	stroke, hardening of arteries	yes	no	herpes
Yes	no	high blood pressure	yes	no	blisters
Yes	no	diabetes	yes	no	stomach problems, ulcers
Yes	no	kidney, bladder diseases	yes	no	thyroid, adrenal diseases
Yes	no	TB, emphysema/other lung diseases	yes	no	tumor /cancer
Yes	no	allergies to_____	yes	no	hepatitis A/B/liver diseases
Yes	no	psychiatric care	yes	no	radiation treatment
Yes	no	blood transfusion	yes	no	chemotherapy
Yes	no	artificial joint or pins			

Yes no Do you have or had any other disease or medical problems that are not listed on this form? If yes please explain_____

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Medical History cont.

Are you taking any of the following?

Yes no recreational drugs. If yes which types?_____
Yes no drugs, medications. If yes which types?_____
Yes no tobacco in any form. If yes how often?_____
Yes no alcohol. If yes how often?_____

Questions for women

Ye no are you/could you be pregnant? If yes how many months?_____
Yes no are you taking birth control pills?_____

Smile design

Yes no are you satisfied with the appearance of your teeth?
Yes no would you like whiter teeth?
Yes no have you had orthodontic (braces) treatment?
Yes no would you like straighter teeth?

To the best of my knowledge, I have answered and completed all of the above information fully and accurately. I will inform my dentist of any changes in my health/medications/information.

Patient signature _____ Date_____

Welcome to Innovative Dental!

1600 Webster Street, Ste. C, San Francisco, CA 94115
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Our Policies

Patient with Third Party Indemnity Insurance, (Individual or Employer Plans):
We bill the insurance company at a usual and a customary fee. You may have contractual obligations between yourself and your plan. It is the patient's responsibility to know what your insurance benefits are and if prior authorization is necessary before services are rendered. Billing your insurance carrier is a courtesy service. We assume NO liability for insurance/eligibility issues, which may deny payment. Your insurance company may hold you responsible for payment of our services at the fee, which we bill. The patient portion, if it applies, will be collected at the time of treatment since we normally do not bill. A bill will only be sent if a service payment is missed or prior arrangements are made. Please review your insurance claim information for your financial responsibilities.

Payment Options:
If paying cash, fees are according to our cash fee schedule and are required to be paid at the time of service unless a prior financial arrangement is made. Major credit cards are accepted. Individuals can also apply for an alternative credit plan with payment options. Returned checks will be charged the fee the bank applies to us.

Collection of Fees:
Patients may need to contact their carrier to be certain Innovative Dental receives payment within 30 days services. Patients may be held financially responsible if payment is not received in a reasonable time or if payment for treatment is denied for any reason. The balance will be due immediately.

Overdue Accounts:
Accounts are considered delinquent when charges become 60 days past due. If an account is sent to collection additional collection fee will be charged to the patient's account. Any account balance which is not on the payment plan and which is over 60 days old will have a finance charge of 1.5% per month (18% APR) added.

Cancellation Fee:
A $25 fee will be charged for each missed appointment. A 24-hour notice must be received during our normal business hours. This fee is not covered by insurance.

By signing below I understand and agree to the above policies and acknowledge the receipt of **Notice of Privacy Practices** (next 2 pages).

Signature:_____ Date:_____

Thank you for choosing Innovative Dental for your dental needs. We look forward to having you as a patient and helping you achieve positive health!

INNOVATIVE DENTAL

1600 Webster Street, Suite C. San Francisco, CA 94115

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. This Notice takes effect 01 / 01 / 2012 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 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 authorize 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 $ 25.00 for a copy of your x-rays on a disc, 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 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 Officer: **Innovative Dental**

Telephone: **(415)500-2116** **Fax:** **(415) 500-2316**

E-mail: **i dentalcare@yahoo.com**

Address: **1600 Webster St Suite C, San Francisco, Ca 94115**