WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

HURT DENTAL CORP.
San Marcos Dental Center
FAMILY/COSMETIC DENTISTRY

SAN MARCOS DENTAL CENTER
162 S. RANCHO SANTA FE ROAD
SAN MARCOS, CALIFORNIA 92078
TELEPHONE (760) 734-4311
FACSIMILE (760) 599-1107
www.sanmarcosdentalcenter.com

Insurance, Fees and Payment Plans

Excellent dental care is a wonderful investment for your comfort, appearance, self-confidence and health. We are sensitive to your needs and financial concerns. If you have any questions or we can help in any way, please feel free to contact us.

Estimate in Writing – Fast & Easy: We will always provide you with a written estimate of cost before we start any treatment. To make payment as fast and easy as possible, we accept Visa, MasterCard, Discover, American Express and debit cards. We also accept checks and cash payment.

Appointments: Once you have reserved time, please do not change your appointment. For visits of 90 minutes or more, we ask for 20% down payment to reserve the doctor's time. We encourage longer appointments when possible to get as much done for you in the fewest visits possible.

Appointment Cancellation: We do require a 48 hour notice to cancel or reschedule your appointment, in order to avoid a cancellation fee. There will be a $50 charge for every hour that we have set aside for your appointment.

Insurance – Express VIP Checkout: Your insurance coverage is an agreement between your carrier and you, and not us. We are happy to help with the processing of your claims, but have "no control" over how much or little they intend to cover for a particular treatment. To accept insurance, we request your estimated co-payment upon arrival so you don't have to wait after your appointment. We also ask that you leave a credit card on file for any additional fees that may come due. When your insurance is received, we automatically credit or debit your charge card to make your payment correct. No more dental bills to worry about!

Estimating Your Benefits: Our staff are experts on insurance. They try to estimate your benefits and answer any questions you may have. In most cases we experience very little difficulty in helping you procur payment. Occasionally, a carrier will be "difficult." If insurance payment is not received after 60 days, we automatically bill your credit card for outstanding balance.

Please do not ask us to change codes to obtain better benefits for you. This is a felony insurance fraud. By law, we are also not allowed to waive deductible, co-payments or non-covered services for you. If you do not provide complete or correct information, or if eligibility cannot be verified, we cannot process your claim and must ask for payment-in-full.

Payment Plans – Making Care Affordable: We offer several payment plans to make the best care fit almost any family budget. For greatest flexibility and the most payment options, we use some wonderful outside services. Some plans are interest-free. Please ask if you would like more information.

Billing Problems: Accounts over 30 days incur 18% annual interest charge. Balances over 90 days are generally referred to a third party for collection. You are responsible for collections costs. The fee for insufficient funds is $35.

Patient Name (print): _____

Patient Signature_____ Date_____

HURT DENTAL CORP.
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General Dentistry Informed Consent

I hereby authorize and direct Dr. Hurt and/or dental auxiliaries of his choice, to perform the following treatments, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids, such as Exams, Cleanings, Root Canals & the following below.

Drugs and Medications: I understand antibiotics, analgesics, and other medications can cause reactions including but not limited to redness, swelling, pain itching, vomiting, and/or anaphylactic shock.

Changes in Treatment: I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgment of the dentist.

Removal of Teeth: Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and authorize the dentist to remove teeth if necessary to have further treatment. I understand the risk involved in having teeth removed of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist, if complications arise during or following treatment, the cost of which is my responsibility.

Crown, Bridges, Inlays/Onlays and Veneers: I understand that sometimes it isn't possible to match the color of natural teeth with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure they are kept in until my permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridges, inlays/ onlays or veneers (including shape, size, fit and color) will be before permanent cementation. It is also my responsibility to return for permanent cementation.

Fillings: (For Insured Patients) I understand that my insurance may not cover tooth colored fillings for my posterior teeth. Dr. Hurt and his associates do not believe in placing restoration containing substances know to cause toxic effects to our patients, in this case mercury; they will not perform these types of services unless there are no viable alternatives. I understand I am responsible for paying the difference between what my insurances pays for silver fillings and Dr. Hurt's UCR fee for tooth color fillings.

I understand that there is risk involved in treatment and hereby acknowledge that these risks will be explained to me, that I will have the opportunity to ask questions regarding the treatment and risks. I acknowledge no guarantee or assurance has been made by anyone regarding my dental treatment, which I have authorized. I understand regardless of any dental coverage I may have, I am responsible for payment of dental fees. Should any dispute arise over dental services provided for me, that is, any dental services allegedly unnecessary, unauthorized or improperly, negligently, or incompetently performed, said dispute will be submitted to a Peer Review by local component of The American Dental Association or comparable committee. The decision of the Peer Review shall be binding in all parties, I have read, understand, and agree to the above

Patient Name (print): _____ Date: _____

Patient Signature: _____

Protecting Your Confidential Health Information Is Important To Us
Updated September 2013

San Marcos Dental Center

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices. Also to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect **September 23, 2013**, 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, and to make new Notice provisions effective for all protected health information that we maintain.

Request for Copies: 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.

Email: SanMarcosDental@hotmail.com, Telephone: 760-734-4311, Fax: 760-599-1107

How Your Health Information May Be Used or Disclosed

We may use and disclose your personal health information ("PHI") for different purposes, including treatment, payment and healthcare operations. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment, Payment & Healthcare Operations: We may use and disclose your PHI for treatments and reimbursement for the treatments and services provided by San Marcos Dental Center or another entity involved with your care, such as sending claims to your dental health plan containing certain health information. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage, to obtain payment from you, an insurance company, or another third party. We may also use or disclose your PHI for connection with our healthcare operations, such as quality assessment and improvement activities, conducting training programs, and licensing activities.

Individual Involved in Your Care or Payment for Your Care: We may disclose your PHI to your family, friends, or another individual identified **by you** to a patient representative. If a person has the authority by law to make healthcare decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclose your PHI to assist in disaster relief efforts.

Required by Law

[We may use or disclose your PHI when we are required to do so by law.]

Public Health Activities: We may disclose your PHI for public health activities, including disclosures to prevent or control disease, injury or disability, report child abuse or neglect, report reactions to medications or problems with product or devices, notify a person of a recall, repair, or replacement of product or devices, notify a person who may have been exposed to a disease or condition, and notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances, as well to authorize federal officials, required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of the PHI of an inmate or patient.

Secretary of HHS: We may disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the healthcare system, government programs, and compliance with civil right laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process instituted by

someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to inform you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors: We may release it to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose your information to funeral directors consistent with applicable law to enable them to carry out their duties.

Your Health Information Rights

You have the right to receive copies of your PHI, with limited exceptions. You must make the request in writing. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law. With limited exceptions, you have the right to receive an accounting of disclosures of your PHI in accordance with applicable law and regulations. To request an accounting of disclosure of your PHI, you must request in writing to the contact information mentioned above.

You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the contact information mention above. Your request must include what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or healthcare operations, and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Revoke: You have the right to revoke the consent of our use and disclosure of your PHI at any time by giving us a written notice of your revocation submitted to the contact information provided above. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you if you revoke this consent.

Authorized Representative Specified By Patients for Health Information Disclosure

I do hereby grant permission for San Marcos Dental Center, to disclose my personal health information to the following personal representative: (spouse, siblings, parents, child, friends, Etc)

Name	Relations to You
1.	
2.	
3.	
4.	
5.	

I, the patient (name) _____, have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Relation to Patient or Description of Personal Representative's Authority

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Release of X-ray Authorization

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialist or dentists. This allows other offices to have a better diagnostic tool available to them which may cost you less and permit you to have access to quicker services.

I understand that x-rays might need to be emailed to other specialist and dentist who are providing services to me and I give my permission for this service.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Relation to Patient or Description of Personal Representative's Authority