DR. JOE
DENTISTRY

# HEALTH HISTORY QUESTIONNAIRE

## General Information

Date: _____

Name: _____ _____ _____ ◯Male ◯Female
Last First Middle Initial

Address: _____ _____
Street Apt/Unit

_____ _____ _____
City State Zip

Birthdate: _____ _____ Social Security: _____-_____-_____

Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

Email: _____ Employer: _____ Occupation: _____

How would you rate your smile (1 – worst, 10 – best): ◯◯◯◯◯◯◯◯◯◯

What is the level of your dental anxiety or nervousness? ◯Mild ◯Moderate ◯Severe

## Dental Insurance

Person responsible for account: _____ Subscriber's name: _____

Relationship to patient: _____ Birthdate: _____

Insurance company: _____ ID #: _____ Group #: _____

Comments: _____

## Medical Health

Y N

◯◯ Any type of TRAUMA to your mouth, jaw or face? If yes, describe:

_____

◯◯ Asked by your medical doctor to PRE-MEDICATE before any dental treatment?

◯◯ Taken FEN-PHEN, REDUX or appetite suppressants? If yes, have you seen a Physician for a cardiac evaluation? _____

◯◯ Have you been HOSPITALIZED in the last FIVE (5) years? If yes, please describe:

_____

Are you ALLERGIC or have you REACTED ADVERSELY to any of the following (check all that apply):

Y N

◯◯ Penicillin
◯◯ Metal: _____
◯◯ Acetaminophen / Tylenol

Y N

◯◯ Latex
◯◯ Ibuprofen
◯◯ Antibiotics: _____

Please list any **other ALLERGIES** to include medications you are allergic to:

_____

Check any of the following that you have had or have presently:

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ◯ | ◯ | High blood pressure | ◯ | ◯ | Diabetes Type 1 / Diabetes Type 2 (Circle One) |
| ◯ | ◯ | Heart disease or heart surgery | ◯ | ◯ | Asthma / breathing disorder |
| ◯ | ◯ | Artificial joints / Heart valves (Circle One) | ◯ | ◯ | Bleeding disorder |
| ◯ | ◯ | Psychological disorder | ◯ | ◯ | Tuberculosis or lung disease |
| ◯ | ◯ | History of drug addiction / alchoholism | ◯ | ◯ | AIDS or HIV+ |
| ◯ | ◯ | Radiation treatment | ◯ | ◯ | Bisphosphonate therapy (for Osteoporosis) |
| ◯ | ◯ | Hepatitis A / Hepatitis B (Circle One) | | | |

| Y | N | |
|---|---|---|
| ◯ | ◯ | Do you have any disease, condition or problem not listed? If yes, please describe: |

_____

Major SURGERIES:

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

**Please list all MEDICATIONS you are currently taking (including prescription and Over-The-Counter) (Example listed below.)**

| Name of medication | Dosage in mg. | Number of times taken | When (daily, as needed) |
|---|---|---|---|
| i.e. Aleve | 275 | 2x | daily |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**For Women Only**

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ◯ | ◯ | Are you pregnant? If yes, due date: _____ | ◯ | ◯ | Are you nursing? |
| ◯ | ◯ | Are you taking birth control pills? | ◯ | ◯ | Hormone replacement? |
| ◯ | ◯ | Could you be pregnant? | | | |

## Emergency

Name: _____ Relationship: _____

Phone: _____

## Authorization

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Name (Print): _____

Signed: _____ Date: _____

DR. JOE
DENTISTRY

## NO CANCELLATION CALL / NO SHOW POLICY

Here at Dr. Joe Dentistry we value our patients and always look forward to caring for you! We mindfully set aside time for each and every one of you to give you the best in quality care!

We kindly ask if you need to cancel or reschedule, please let us know within 2 WORKING DAYS so others may reserve time to see Dr. Joe. No call no show last minute cancel will be documented and future appointments will no longer be reserved or pre appointed for patients with multiple no shows. Patients with multiple last minute cancel, no call no show will be seeing as same day only appointments if there is any availability. Please plan accordingly, Thank you

We understand that emergencies happen, and we will utilize this policy at our discretion.

We appreciate your understanding and cooperation!

Signed: _____ Date: _____

## NOTICE of PRIVACY PRACTICES - HIPAA

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review 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 effect May 5, 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. 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 as 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 your 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 or get copies of your health information with limited exceptions. You may request that we provide you copies in a format other than photocopies. We will use the format you requested unless we cannot practically 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 $25.00 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 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 May 5, 2013. 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 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 alternative locations. (You must make 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 your location you requested.
Amendment: You have the right to request that we amend your health information. (Your request must be 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 website or by electronic mail (email), 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 violated your privacy rights, or 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 alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also 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 the U.S. Department of Health and Human Service.
I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signed: _____ Date: _____

# ARBITRATION

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:

The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law. The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable): Patient understand and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P.1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error. The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRATICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL,SEE ARTICLE I OF THIS CONTRACT.

Signed: _____ Date: _____

Financial Agreement

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information
regarding our dental fees and discussing payment options. All patient portions and deductibles are due at the time of service. We will provide you with an estimate of
the total fees expected. Please understand that this will ONLY be an estimate. Treatment needs can change for a variety of unforeseen reasons. Whenever possible,
we will inform you of any treatment changes that will affect your financial estimate. Should you have any questions concerning your treatment, treatment sequence,
or fees for services, please ask for clarification before treatment is begun.
Our financial policy is as follows:
1) We accept cash, personal checks, and most major credit cards including MasterCard, Visa, American Express.
2) Full (100%) payment is due at the time of service.
3) Payment plans for certain procedures are available through Care Credit with payment options available up to four years at fixed rates.
4) Insurance -- insurance is a contract between the patient and/or employer and the insurance company. We cannot be responsible for payment by the insurance
company. The responsibility for payment belongs to the patient.
5) We will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of benefits may be advisable if there is a
question regarding coverage.
6) We will accept assignment of benefits subject to verification of insurance coverage.
7) First office visits that are Emergency Visits -- full payment will be expected regardless of insurance.
8) Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment is begun.
9) A twenty four (24) hour notice is required to cancel an appointment. If unable to give a twenty four (24) hour notice, a minimum of $40.00 cancellation fee will be
applied.
We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, a minimum 50% co-payment is due at the time of
service.
Should your insurance plan be denied, full payment is expected at the time of service unless prior arrangements have been made. A monthly finance charge of 1.5%
will be added to any unpaid balances after 30 days from date of service.
Please remember that you are responsible for timely payment of your account. Should it become necessary to refer your account to an agency or attorney for
collection, you will also be responsible for all costs associated with the collection including attorney's fees and court costs.
I understand the above policy and agree to the terms herein.

Signed: _____ Date: _____