

PATIENT NAME _____ BIRTHDATE _____ AGE _____

HOME PHONE _____ SEX _____

HOME ADDRESS _____ CITY & ZIP _____

MAILING ADDRESS (if different from above) _____

EMPLOYED BY _____ JOB TITLE _____

WORK ADDRESS _____ WORK PHONE# _____

DENTIST _____ LAST VIST _____ REFERRED BY _____

MARITAL STATUS: SINGLE _____ MARRIED _____ SEPARATED _____ REMARRIED _____ WIDOWED _____

SPOUSE'S NAME _____ BIRTHDATE _____

ADDRESS (if different from patient) _____

EMPLOYED BY _____ JOB TITLE _____

WORK ADDRESS _____ WORK PHONE# _____

MEDICAL HISTORY

YES NO

DENTAL HISTORY

Have you been diagnosed or treated for any of the following

- Diabetes Heart Murmur Emotional problems
- Epilepsy Heart condition Endocrine disorders
- Polio Anemia Bone disorders
- Arthritis Prolonged bleeding Fainting, dizziness
- Asthma Hepatitis Tonsils removed
- Tuberculosis Gastro-intestinal Adenoids removed
- Rheumatic fever Cerebral Palsy

- Have you experienced any unfavorable reaction from any previous dental treatment that you are aware of?
- Do you breathe predominantly through the mouth?
- Do you have any speech problems?
- Do you clench or grind teeth?
- Do you have pain or clicking upon closing the mouth?
- Have you had any severe head or face injuries? YES NO
When? _____
- Have any teeth been injured or chipped due to accidents?
When? _____
- Any noticeable difficulty in chewing or swallowing food?
- Has patient been informed of any extra or missing teeth?
- Have any teeth (baby or permanent) been removed by extraction? Why _____
- Has a dentist ever placed a retainer or space maintainer?
- Has any member of the family had orthodontic treatment?
Who? _____
- Have you had any previous orthodontic consultation or treatment?
- Would you mind wearing braces? _____ headgear? _____
- Do you want your teeth straightened?

- Are you presently under a physician's care?
for _____
- Are you taking any pills, medications, or drugs?

- Have you ever had an unusual reaction to medication?

- Are you allergic to anything? _____
- Do you have a tendency to colds _____ sore throats _____
Ear infections _____
- Have you had any major surgery? For _____
- Do you have a chronic problem with your kidneys _____
Lungs? _____ Liver? _____
- Do you have any other medical problems not mentioned above?

I have examined the above information and it is true and correct

Date: _____ Signature: _____

JASON DORMINEY, D.M.D.

9717 Elk Grove-Florin Rd., #D
Elk Grove, CA. 95624
916-686-6900

9296 Vintage Park Dr., #300
Sacramento, CA. 95829
916-681-0987

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 04/13/03 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 and 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 judgement 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 \$.20 for each page, \$50 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 - months period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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: Jason Dorminey, D.M.D.

Telephone: 916-686-6900 or 916-681-0987

Address: 9717 Elk Grove - Florin R., #D or 9296 Vintage Park Drive
Elk Grove, CA. 95624 Sacramento, CA. 95829

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PATIENT/SPOUSE- INFORMATION AND INSURANCE QUESTIONNAIRE

FILL OUT SHADED AREAS ONLY FOR BOTH PATIENT AND SPOUSE

Date _____

PATIENT NAME _____ **BIRTHDATE** _____

SOCIAL SECURITY _____ **DRIVER'S LICENSE** _____

EMPLOYER _____ **INSURANCE CO.** _____ **GROUP #** _____

INSURANCE PHONE NUMBER _____

EFFECTIVE DATE _____ **WAITING PERIOD** _____ **DEDUCTIBLE** _____

PERCENTAGE _____ **Benefit for:** employee _____ spouse _____

AMOUNT/MAX _____ (In network same as out of network?) children age _____ students to age _____

BILLING PAYS: Monthly _____ Quarterly _____ Auto _____ Semi Annually _____ Cont TX _____

BILLING ADDRESS: _____

Records/Consult-out of ortho: YES _____ NO _____ Standard coordination of benefits: YES _____ NO _____

SPOUSE'S NAME _____ **BIRTHDATE** _____

SOCIAL SECURITY # _____ **DRIVER'S LICENSE** _____

EMPLOYER _____ **INSURANCE COMPANY** _____ **GROUP #** _____

INSURANCE PHONE NUMBER _____

EFFECTIVE DATE _____ **WAITING PERIODS** _____ **DEDUCTIBLE** _____

PERCENTAGE _____ **Benefit for:** employee _____ spouse _____

AMOUNT MAX _____ children age _____ students to age _____

BILLING PAYS: Monthly _____ Quarterly _____ Auto _____ Semi annually _____ Cont TX _____

BILLING ADDRESS: _____

Records/Consult--out of ortho: YES _____ NO _____ Standard coordination of benefits: YES _____ NO _____

RESPONSIBILITY DISCLAIMER: The patient is responsible for any payments not made by their insurance. We will process any insurance form, but we are not responsible for payemtn. Patient is responsible for notifying the office if there are any changes of insurance or eligibility.

RECORDS PRIVACY STATEMENT: All records are kept private in our office. Financial statements are only given to the financially responsible party, unless that responsible party gives specific release. At this time all claims are faxed or sent by mail. No claim forms are sent electronically; therefore they are not being submitted through a clearinghouse. X-rays and records may be sent or shared with other dentist.

I have read the above statement and understand.

Patient signature _____ Date _____