ROSEVILLE DENTAL GROUP

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 4/14/03 , 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 provide 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 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 you $0.25 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 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 Heath 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: Beth Phillips

Telephone: 916-782-7783 Fax: 916-782-4699

E-mail: rdg@surewest.net

Address: 1441 Secret Ravine Pkwy #100

Roseville, CA 95661

ROSEVILLE DENTAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____

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)

_____

_____

_____

ROSEVILLE DENTAL GROUP

1441 SECRET RAVINE PKWY., SUITE 100, ROSEVILLE, CA 95661
TELEPHONE (916) 782-7783 FAX (916) 782-4699

Date _____

PATIENT INFORMATION

Home # _____ Work # _____ Cell # _____

E-mail Address _____

PATIENT INFORMATION

Name _____
Address _____
City, State, Zip _____
Birth date ____/____/____ Age ____ ❑ M ❑ F
❑ Married ❑ Widowed ❑ Unmarried
Social Security # _____ - _____ - _____
Employer _____
Business Address _____
City, State, Zip _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name _____
Employer _____
Business Address _____
City, State, Zip _____
Business Phone _____ Ext. # _____
Position _____

Whom may we thank for referring you? _____

GENERAL INFORMATION

Person to contact for emergency _____
Relationship to Patient _____ Their telephone # _____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

PRIMARY INSURANCE

Name of insured _____
Insured person Date of Birth ____/____/____
Insured Social Security # _____ - _____ - _____
Insurance Company _____
Insurance Address _____
City, State, Zip _____
Insurance phone # _____
Local # or Group # _____
Employer _____ Date employed _____

SECONDARY INSURANCE

Name of insured _____
Insured person Date of Birth ____/____/____
Insured Social Security # _____ - _____ - _____
Insurance Company _____
Insurance Address _____
City, State, Zip _____
Insurance phone # _____
Local # or Group # _____
Employer _____ Date employed _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

The main goal of this office is to provide you with the best quality dental care available. This is based on a friendly, but businesslike understanding between doctor and patient. We ask that all fees and charges for treatment be paid the date they are incurred, unless previous arrangements have been made. There is a service charge on all accounts past 60 days. If an appointment must be changed we require 24 (twenty-four) hour notice. You may be charged for missed or broken appointments. As members of the Credit Bureau of Placer County, we reserve the right to make credit inquiries.

As a courtesy, we bill insurance claims for our patients. Please remember, your insurance policy is a contract between you and the insurance company, not between the doctor and the insurance company. We cannot guarantee your claim will be paid, or how much will be paid. Financial responsibility for services rests with the patient and/or family. We will be happy to help you if you need assistance with your insurance claim. If your insurance has not paid after 60 days, we ask that you pay the balance of your account and that you contact your insurance company regarding settlement.

I understand that payment is due according to these arrangements. I authorize my treatment or treatment of the patient listed above.

_____

Patient or Parent / Guardian Signature (If patient is a minor)

MEDICAL HISTORY

Please answer **EACH** question

Do you have, or have you had any of the following: Please circle Yes or No

Heart Ailments or Heart Surgery	Yes No	Tumors or Growths	Yes No	Tuberculosis	Yes No
Pacemaker	Yes No	Asthma or Hay Fever	Yes No	Kidney Disease	Yes No
High Blood Pressure	Yes No	Anemia	Yes No	Diabetes	Yes No
Heart Murmur	Yes No	Excessive Bleeding	Yes No	Epilepsy	Yes No
Artificial Joints, Pins, or Screws placed	Yes No	Blood Diseases	Yes No	Stroke	Yes No
Hepatitis, Jaundice, or Liver Disease	Yes No	Stomach Ulcers	Yes No	Allergies	Yes No
Radiation Treatment of any kind	Yes No	Nervous Disorders	Yes No	HIV/AIDS	Yes No
Rheumatism or Arthritis	Yes No	Rheumatic Fever	Yes No	Herpes	Yes No
Latex Sensitivity/Allergy	Yes No	Respiratory Disease	Yes No	Sinus Trouble	Yes No
Fainting Spells or Seizures	Yes No	Venereal Disease	Yes No	Head Injuries	Yes No
Fever Blisters / Cold Sores	Yes No	Osteoporosis (bisphonates)	Yes No		

1. Are you in good health? Yes No
2. Date of last medical exam _____
3. Have you ever been hospitalized? Yes No
   When _____
   Why _____
4. Are you taking any drugs, medications, or supplements? Yes No
   If so, please list: _____
5. Do you have any disease, problem, illness or condition you think I should know about?
   What _____
   When _____
6. Are you sensitive or allergic to any drugs? Yes No
   If so, which _____
7. Do you require Pre-Medication for dental treatment? Yes No
8. Are you now under the care of a Medical Doctor? Yes No
9. Have you had any serious illness? Yes No
10. Blood pressure, if known _____
11. Are you a tobacco user? Yes No

Physician's Name _____
Address _____
Phone (_____) _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No
Are you pregnant? Yes No If yes, what month? _____
Physician's Name _____ Phone (_____) _____

"I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge."

_____
Patient or Parent / Guardian Signature (If patient is a minor)

DENTAL HISTORY

1. How long since you've been to a dentist? _____
2. Previous dentist name _____
3. When was your last set of full mouth x-rays (14 or more)? _____
4. How often do you floss your teeth? _____
5. How often do you brush your teeth? _____
6. Have you ever been treated for periodontal disease? Yes No
7. Have you ever had any complications from an extraction? Yes No
8. Do you grind your teeth? Yes No
9. What would you change about the appearance of your teeth and smile? *(circle) Whiter Straighter Longer Shorter Less Crowded Close the gaps*
10. Have you ever had a popping or clicking near your ear when you chew? Yes No
11. Do your gums bleed when you brush or floss? Yes No
12. Do you have sores, blisters or swelling on your gums, lips or cheeks? Yes No
13. Have you ever had orthodontic treatment? Yes No
14. Do you have pain of any kind in the head or neck region? Please explain _____

Reviewed by: _____

MEDICAL UPDATE INFORMATION

Date: _____
Changes: _____

Signature: _____

Date: _____
Changes: _____

Signature: _____