Brentwood Dental Center

Welcome to Brentwood Dental Center. In order to serve you, please complete the following confidential information. Thank you.

Contact Information

Date : _____

Name: _____

Preferred Name: _____

Spouse / Partner's Name: _____

Address: _____

City _____State_____ Zip_____

Home Phone: _____-_____-_____

Cell Phone: _____-_____-_____

Email: _____

Birthdate: _____-_____-_____ Age: _____

Social Security Number:_____-_____-_____

__Marrried, __Single, __Divorced, ___Domestic Partner

Emergency Contact: _____

Emergency Phone: _____-_____-_____

Dental Benefit Information

Insurance Name: _____

Subscriber: _____

Employer: _____

Group#_____Id#_____

Claim Address: _____

City _____State_____ Zip _____

Spouse / Partner Information
(if you have double coverage)

Insurance Name: _____

Subscriber: _____

Date of Birth: _____

Employer: _____

Group#_____Id#_____

Claim Address: _____

City _____State_____ Zip_____

Account Information

Person responsible for account?

_____

Your Employer: _____

Occupation: _____

How Did You Find Out About Our Practice

Referred by a friend or family member?

Who?:_____

Other:_____

Brentwood Dental Center

Name _____

Because dentistry requires the use of drugs or invasive procedures, it is important that we have certain information about your health. All information on this form is strictly CONFIDENTIAL, and cannot be released to any other person or agency without your written permission. Please answer all of the following questions:

1. What is your estimate of your general health? (circle) POOR FAIR GOOD EXCELLENT
2. Have you been hospitalized during the past two years? Yes NO Reason? _____
3. Are you currently under the care of a physician? Yes NO Reason? _____
4. Date of last physical examination? _____
5. Physician name / contact information _____ Phone # _____
6. Do you have or have you had any of the following:

Cardiovascular Disorders:

Yes	No	
☐	☐	High blood pressure
☐	☐	Congenital Heart Disease
☐	☐	Rheumatic fever
☐	☐	Heart Murmur
☐	☐	Heart Pacemaker
☐	☐	Vascular graft
☐	☐	Heart or bypass surgery
☐	☐	Artificial Heart Valve
☐	☐	Heart Attack
☐	☐	Congestive Heart Failure
☐	☐	Awaken with breathing difficulty
☐	☐	Angina pectoris / chest pain
☐	☐	Swollen ankles
☐	☐	Irregular or rapid heart beats
☐	☐	Stroke

Respiratory Disorders:

Yes	No	
☐	☐	Emphysema or Asthma
☐	☐	Hay fever
☐	☐	Chronic cough or Bronchitis
☐	☐	Tuberculosis
☐	☐	Sinus problems
☐	☐	Breathing problems

Muscular-Skeletal/CNS/ Developmental Disorders:

Yes	No	
☐	☐	Frequent headaches
☐	☐	Fainting/ Loss of consciousness
☐	☐	Seizures or epilepsy
☐	☐	Visual impairment
☐	☐	Hearing impairment
☐	☐	Artificial joint if yes, surgery date
☐	☐	Arthritis or bone disease
☐	☐	Muscle disease
☐	☐	Spinal cord injury or paralysis
☐	☐	Osteoporosis
☐	☐	Autism
☐	☐	Alzheimer's disease
☐	☐	Dementia

Gastrointestinal/ Genitourinary Disorders:

Yes	No	
☐	☐	Colitis or ulcers
☐	☐	Hepatitis / Jaundice / Liver disease
☐	☐	Renal dialysis
☐	☐	Kidney transplant
☐	☐	Kidney disease
☐	☐	Syphilis, Gonorrhea, other STD
☐	☐	Herpes
☐	☐	Frequent canker sore
☐	☐	Chronic diarrhea
☐	☐	Frequent vomiting
☐	☐	Gastric reflux/ GERD

Hematologic/ Endocrine/ Immune Disorders:

Yes	No	
☐	☐	Blood transfusion
☐	☐	Anemia / Leukemia / Lymphoma
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Blood clots or Thrombosis
☐	☐	Diabetes if yes type:
☐	☐	Thyroid disease
☐	☐	Adrenal gland disease
☐	☐	HIV / AIDS
☐	☐	Kaposi's Sarcoma
☐	☐	Bleeding or brusing easily
☐	☐	Sudden weight loss or gain
☐	☐	Frequent thirst
☐	☐	Frequent hunger
☐	☐	Frequent urination
☐	☐	Autoimmune disorders/ Lupus

Psychiatric Disorders:

Yes	No	
☐	☐	Depression
☐	☐	Anxiety / Nervousness
☐	☐	Eating disorders
☐	☐	Past / present psychiatric treatment

Is there anything else we should know about your medical history?

_____

Family history (Grandparents, Parents, Siblings):

Yes	No	
☐	☐	Diabetes
☐	☐	Heart Disease
☐	☐	Bleeding disorder
☐	☐	Cancer

Allergies:

Yes	No	
☐	☐	Penicillin or other antibiotics
☐	☐	Sulfa drugs
☐	☐	Novocaine / Dental anesthetics
☐	☐	Aspirin
☐	☐	Codeine or other narcotics
☐	☐	Latex products
☐	☐	Metals / Plastics / Sulfites
☐	☐	Hay fever / seasonal allergy
☐	☐	Sedatives or sleeping pills
☐	☐	Others: _____

Females:

Yes	No	
☐	☐	Pregnant
☐	☐	Anticipate being pregnant
☐	☐	Taking birth control pills
☐	☐	Breast feeding

Cancer/ Tumor :

Yes	No	
☐	☐	Diagnosis _____ Year _____
☐	☐	Surgery_____
☐	☐	Radiation _____
☐	☐	Chemotherapy _____

Medications (Including aspirin and herbal supplements):

Yes	No	
☐	☐	_____ _____ _____ _____ _____

Social history (Past / Present):

Yes	No	
☐	☐	Smoking
☐	☐	Smokeless tobacco
☐	☐	Alcohol drinks per week _____
☐	☐	Substance abuse

I certify that above information is correct to the best of my knoweldge. I agree to keep this office inform of any changes in my health or any medications I may be taking.

_____

Signature of Patient, Parent or Guardian Date Reviewed by

Brentwood Dental Center

Expectations Regarding Appointments

To Our Clients

At Brentwood Dental Center we work very hard at treating our clients as unique individuals. We try to remain responsive to each person's needs, preferring to rely on common sense and common courtesy rather than hard and fast "Policies". Unlike many dental practices where the dentist bounces from room to room, we see only one client at a time. When you book an appointment with us, you have our undivided attention for the length of that appointment.

Short-notice cancellations or missed appointments affect many people. From an operations standpoint, missed appointments increase our cost of providing dental care - costs that ultimately must be passed on to you, our client. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other clients needing - and wanting - care.

For these reasons we are asking you to read and agree to these expectations:

1. Please respect our time and that of other clients by giving us a minimum of ***48 hours*** notice to cancel or change an appointment.

2. For cancellations or missed appointments where less than ***48 hours*** notice is given, a charge of $95.00 per hour ($65.00 per hour for hygiene) of scheduled time will be made.

Such policies have been standard practice for other health care providers who work one-on- one with their clients. We thank you in advance for your understanding.

Signature: _____ Date: _____.

NOTICE OF PRIVACY PRACTICES

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect _____,_____ , 20_____, 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

- **Treatment:**

We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

- **Payment:**

We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

- **Healthcare Operations:**

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

- **Unsecured Email:**

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

- **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 may contact you about products or services related to your treatment, case management or care
coordination, or to propose other treatments or health-related benefits and services in which you may be
interested. We may also encourage you to purchase a product or service when you visit our office. If you
are currently an enrollee of a dental plan, we may receive payment for communications to you in relation
to our provision, coordination, or management of your dental care, including our coordination or
management of your health care with a third party, our consultation with other health care providers
relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health
information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

- **Change of Ownership:**

If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

- **Required by Law:**

We may use or disclose your health information when we are required to do so by law.

- **Public Health:**

We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

- **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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

- **Appointment Reminders:**

We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

- **Sign In Sheet and Announcement:**

Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

- **Disclosure Accounting:**

You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

- **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 of how payments will be handled under the alternative means or location you request.

- **Breach Notification:**

In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

- **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.Questions and Complaints:

COMPLAINTS

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Brentwood Dental Center
Telephone: 310-820-6696 , Fax: 310-820-0916
E-mail: office@brentwooddentalcenter.com
Address: 11645 Wilshire Blvd, Suite704, Los Angeles, California 90025

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Brentwood Dental Center
11645 Wilshire Blvd, Suite704
Los Angeles, CA 90025

*** You May Refuse to Sign This Acknowledgement ***

I have received a copy of this Brentwood Dental Center's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to Patient: _____

For Program 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)