Welcome

We are pleased to welcome you to our practice!

Patient Information

Patient's last:_____First:_____M.I.:_____Date: _____

Birth Date:_____Social Security #_____Sex:_____Family Status: Single / Married / Divorced / Child / Other

Home Phone:_____ Work:_____Cell:_____Other:_____

Physical Address:_____ Apt #_____City:_____State:_____Zip:_____

Mailing Address (PO Box, etc.): _____ City:_____State:_____Zip:_____

Email Address:_____

Preferred appointment times (please circle): Morning Afternoon Evening Anytime Days (please circle): Mon Tues Wed Thurs Fri Sat

How do you prefer to be contacted? Phone: Yes No / Email: Yes No / Text Messaging: Yes No

What Pharmacy do you prefer? _____City: _____

Emergency Contact: Name:_____Phone:_____

Whom may we thank for referring you to our practice?_____

Dental History

Date of Last Dental Visit:_____

Why have you come to the dentist today?_____

_____

_____

Are you currently in pain? Y N

Have you experienced problems associated with any previous dental work? Y N

Do you now or have you ever experienced pain/ discomfort in your jaw (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you Brush Daily? Y N Floss Daily? Y N

Are you happy with the way your smile looks? Y N

Type of bristles on your brush: Hard Med Soft

Do you use anything in addition to your brush and floss? Y N

If yes, what?_____

_____

Do your gums bleed? Y N

Have you ever had periodontal disease?_____

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

_____

Have you lost any teeth? Y N If yes, why?_____

_____

Do you still have your wisdom teeth? Y N

Do you need to ***PRE-MED*** before dental work? Y N

If not, what would you change?_____

_____

_____

Have you experienced the following dental problems?

Bad Breath	Y	N	Fignernail biting	Y	N	Mouth Breathing	Y	N
Bleeding gums	Y	N	Food collection between teeth	Y	N	Mouth pain, brushing	Y	N
Blisters on lips or mouth	Y	N	Chew on foreign objects	Y	N	Orthodontic treatment	Y	N
Burning sensation on tongue	Y	N	Grinding teeth	Y	N	Pain around ear	Y	N
Chew on one side of mouth	Y	N	Gums swollen or tender	Y	N	Sensitivity to cold	Y	N
Cigarette, pipe, or cigar smoking	Y	N	Jaw pain or tiredness	Y	N	Sensitivity to heat	Y	N
Clicking or popping of jaw	Y	N	Lip or cheek biting	Y	N	Sensitivity to sweets	Y	N
Dry mouth	Y	N	Loose teeth/broken filings	Y	N	Sensitivity when biting	Y	N

How often do you Floss your teeth?_____ How often do you Brush your teeth?_____

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask. We will be happy to help you.

Medical History

Do you have a personal physician? Y N

Physician's Name _____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____ Date of Last Visit?_____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Y N

If yes, please explain:_____

_____

For Women: Are you pregnant? Unsure Y or N Week #_____

Are you taking birth control? Y N Are you nursing? Y N

Are you ***ALLERGIC*** *to* any of the following?

Aspirin	Codeine	Jewelry	Erythromycin
Barbiturates	Sulfa Drugs	Sedatives	Penicillin
Tetracycline	Dental Anesthetics	Latex	Other

Please list additional drugs that cause allergic reactions:_____

_____

_____

Have you ever been hospitalized or had a serious illness or operation? Y N

If yes, date and condition treated:_____

Do you smoke or use tobacco in any other forms? Y N

Are you taking any of the following?

Acetaminophen	Blood Pressure Medication	Nitroglycerin	Antibiotics	Cold Remedies	Recreational Drugs
Antihistamines	Digitalis/Heart	Medication	Steroids/Cortisone	Aspirin or Ibuprofen	Tranquilizers
Thyroid Medicine	Insulin/Diabetes Drugs	Blood Thinners	Bisphosphonates	Other_____	

Are you taking any prescriptions or over the counter drugs? Y N If yes, please list each one:_____

_____

Have you experienced the following?

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
Alcohol Abuse	Y	N	Fever Blisters	Y	N	Persistent Cough	Y	N
Anemia	Y	N	Frequent Headaches	Y	N	Psychiatric Problems	Y	N
Arthritis	Y	N	Glaucoma	Y	N	Radiation Treatment	Y	N
Artificial Bones/Joints	Y	N	Hay Fever	Y	N	Rheumatic Fever	Y	N
Artificial Valves	Y	N	Heart Attack	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Heart Surgery	Y	N	Severe Headaches	Y	N
Cancer	Y	N	Hemophilia	Y	N	Shingles	Y	N
Chemotherapy	Y	N	Hepatitis: A / B / C	Y	N	Sickle Cell Disease	Y	N
Chicken Pox	Y	N	Herpes	Y	N	Sinus Problems	Y	N
Colitis	Y	N	High Blood Pressure	Y	N	Steroid Therapy	Y	N
Congenital Heart Defect	Y	N	HIV+/AIDS	Y	N	Stroke	Y	N
Diabetes: Type 1 / Type 2	Y	N	Hospitalized	Y	N	Thyroid Problems	Y	N
Difficulty Breathing	Y	N	Kidney Problems	Y	N	Tonsillitis	Y	N
Drug Abuse	Y	N	Liver Disease	Y	N	Tuberculosis (TB)	Y	N
Emphysema	Y	N	Low Blood Pressure	Y	N	Ulcers	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N

Please List any serious medical condition(s) that you have experienced:_____

_____

*I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify Dr. Gurvir S. Dhami DDS, of any change in my health or medication prior to treatment.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Gurvir S. Dhami DDS **Assistant**

I have verbally reviewed the Medical/Dental information above with the patient named herein. Initials_____ Date_____

Doctor's Comments:_____

_____

Payment Information

(FOR MINORS UNDER 18) Responsible Party Information

Name:_____ Relation to Patient_____

Social Security #_____ Birth Date:_____

Home Phone: _____ Work:_____ Other:_____

Address:_____

City:_____ State:_____ Zip:_____

Employment Information

Employer Name:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Dental Insurance Information

Primary Dental Insurance-

Dental Insurance Company:_____ ID#_____

Name of Policy Holder:_____ Is Policy Holder a Patient? Y N

Social Security #_____ Birth Date:_____

Dental Insurance Address:_____ City:_____ State:_____ Zip:_____

Secondary Dental Insurance-

Dental Insurance Company:_____ ID#_____

Name of Policy Holder:_____ Is Policy Holder a Patient? Y N

Social Security #_____ Birth Date:_____

Dental Insurance Address:_____ City:_____ State:_____ Zip:_____

Consent of Services

I authorize Dr. Gurvir S. Dhami to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication or therapy that may be indicated, authorize and consent that the Doctor choose and employ such assistance as he deems necessary. ***I also understand that, I the patient am responsibility for payment for Dental Services provided by this office for me and/or my dependents is solely mine;*** due and payable at the time of services are rendered. ***As a courtesy, our office will bill my insurance.*** Financial arrangements may be made in advance, including billing for dental insurance. However, I acknowledge that I am responsible for payment for all services rendered.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for professional services, I agree to pay the full amount owed said services to Gurvir Dhami DDS, at the time services are rendered or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ _____ _____

Signature of Patient, parent or guardian **Date** Relationship to patient

Scheduling & Consent of Disclosure

Scheduling your Next Appointment

We make every effort to schedule appointments for the convenience of our patients. We need your cooperation to ensure that everyone has an opportunity for timely treatment. Please keep the following in mind:

Early morning, late afternoon, appointments and Saturday (By appointment only) are in great demand in our office. We will be happy to schedule you for one of these times if one is available, but we ask that you please make every effort to keep the appointment. Last minute changes often prevent us from offering these popular times to other patients who have requested them.

We fully understand that there are times when illness or unexpected obligations cause patients to reschedule appointments. However, we ask that you honor your appointments whenever possible so that you can stay on schedule and derive the maximum benefit from your treatment.

Notice: We do not double/triple- book at this office and as a courtesy to other patients, we request that you notify us within 24 hours if you need to change your scheduled appointment.

As of June 1, 2015: There will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment.

ALL Saturday Appointments: There will be a fee of $100.00 assessed if we do not receive a call to cancel an appointment. Failure to do so could result in termination of services.

Thank you for choosing us for your dental care. If at any time, you have any questions about any of our services, please feel free to call us.

(Signature)_____ **(Date)**_____

Consent of Disclosure *(For the usage and/or Disclosure of Protected Health Information)*

I hereby give consent to Gurvir S. Dhami DDS, and all health care providers furnishing care within the offices of Gurvir S. Dhami DDS, to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered by person or by mail, but it will only be effective when we physically receive it. Your cancellation will not be effective to the extent that we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of you protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting the Office Manager.

Patient Name (Please Print)_____

Signature of Patient_____ **Date**____/____/____

If you are signing as the patient's representative:

Relationship_____

Address for cancelation: Your cancellation will be effective, upon receipt, at the following address:

Gurvir S. Dhami D.D.S., 9461 Deschutes Road, Suite 2 Palo Cedro, CA 96073

HIPAA PRIVACY FORM

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

{Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 04/14/2003, 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 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 authorize federal official's 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 $1.00 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 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: Gurvir Dhami DDS

Telephone: 530-547-5757/Fax: 530-547-5755 Address: 9461 Deschutes Road, Suite 2 Palo Cedro, CA 96073

Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign this Acknowledgement***

I, **(Print name),** _____ have received a copy of this office's Notice of Privacy Practices.

(Signature)_____ **(Date)**_____

******* OFFICE USE ONLY BELOW ********* OFFICE USE ONLY BELOW ******** OFFICE USE ONLY BELOW *******

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 _____Communication barriers prohibited obtaining the acknowledgement _____An emergency situation prevented us from obtaining acknowledgement _____Other (Please Specify)_____