SPRING DENTAL GROUP
LONG BEACH, CALIFORNIA

NEW PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFORMATION

Patient Name: _____ Date: _____
Sex: □ Female □ Male
Marital Status: □ Married □ Single □ Child □ Other _____
Social Security #: _____ Birth Date: ___/___/_____
Phone (Home):_____(Work) _____Ext:_____Best Time: _____
Cell Phone: _____Email: _____
Address: _____ Apartment # _____
Email Address: _____
Who may we thank for referring you to our office? _____

Nearest relative not living with you: Name: _____
Address: _____
Telephone Number: _____

INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name _____ Group # _____
Insured's Employer: _____ Insured's SS# _____
Insured's Birthdate: _____ Insured's Relationship to Patient: _____

Secondary Insurance
Insurance Co. Name _____ Group # _____
Insured's Employer: _____ Insured's SS# _____
Insured's Birthdate: _____ Insured's Relationship to Patient: _____

ASSIGNMENT & RELEASE:
I certify that I and/or my dependents have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to SPRING DENTAL GROUP all insurance benefits for services rendered, otherwise payable to me, if any. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Spring Dental Group masy use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when I revoke it in writing.

_____
Signature of Patient, Insured, Guardian, or Personal Representative

_____
Printed Name of Patient, Insured, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

NEW PATIENT INFORMATION AND HEALTH HISTORY, CONT.

Patient: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

_____
Name Relationship to patient

_____
Address Telephone

Social Security #: _____ Driver's License #: _____

EMERGENCY CONTACT INFORMATION

_____
Name

_____
Telephone Number Relationship to patient

HEALTH HISTORY

Do you currently have, or have you previously had, any of the following health conditions?

☐ Yes	☐ No	Acid Reflux/ GERD	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Allergies	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Alzheimer's Disease	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Mental Disorder
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Gastrointestinal problems	☐ Yes	☐ No	Methamphetamine Use
☐ Yes	☐ No	Anorexia/Bulimia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Nervous System Disorder
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Growth/Tumor	☐ Yes	☐ No	Osteoporosis
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Renal Failure
☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No	Respiratory Problems
☐ Yes	☐ No	Bleeding (Excessive)	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Rheumatic/Scarlet Fever
☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Rheumatoid Arthritis
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Problems
☐ Yes	☐ No	Celiac Disease	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Sjogren's Syndrome
☐ Yes	☐ No	Cleft Lip/Cleft Palate	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	Sleep Apnea
☐ Yes	☐ No	Cystic Fibrosis	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No	Stomach Ulcers
☐ Yes	☐ No	Developmental Disability	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Diabetes Type 1	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No	Thyroid
☐ Yes	☐ No	Diabetes Type 2	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease

For any to which you responded "yes," please explain, including approximate date of onset (if known):

_____
_____
_____
_____

Patient: _____

HEALTH HISTORY, CONTINUED

Are you allergic to latex? ☐ Yes ☐ No
Are you allergic to codeine? ☐ Yes ☐ No
Are you allergic to penicillin? ☐ Yes ☐ No

Do you have any other allergies? ☐ Yes ☐ No If yes, please list: _____
_____

WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, what is your due date? _____

Do you have any sensitivity to metals? ☐ Yes ☐ No
Do you have a persistent or bloody cough? ☐ Yes ☐ No
Do you have, or have you experienced, any of the following:

☐ Yes ☐ No Shortness of breath on mild exertion?
☐ Yes ☐ No Chest pain after or during exertion?
☐ Yes ☐ No Swollen ankles?
☐ Yes ☐ No Emotional problems, stress, or tension that caused you concern?
☐ Yes ☐ No A tumor or abnormal growth?

Do you have any artificial joints? ☐ Yes ☐ No If yes, please list: _____
_____

Do you wear corrective lenses or glasses? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No

Are you currently undergoing chemotherapy ☐ Yes ☐ No
Are you currently undergoing radiation treatment? = ☐ Yes ☐ No
Will you be beginning chemotherapy and/or radiation treatment in the near future? ☐ Yes ☐ No
If you have recently completed cancer treatment, please state the type of treatment and the date the last dosage was administered: _____

Are you currently taking, or have you previously taken, diet pills/ Fen-Fen? ☐ Yes ☐ No

Do you currently use tobacco products? ☐ Yes ☐ No If yes, please state the type of tobacco used and how much you use on a daily basis: _____

Your medical health may affect your dental treatment. Are there any other medical conditions we should know about? _____
_____

Please list all current medications (including over-the-counter, vitamins, and supplements):
_____
_____
_____

Patient: _____

DENTAL HISTORY

Are you experiencing dental pain today? ☐ Yes ☐ No

If yes, where? _____ For how long? _____ Is the pain constant? ☐ Yes ☐ No

Are you having sensitivity to hot or cold? ☐ Yes ☐ No If yes, where? _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Are any of your teeth loose, or are you concerned about teeth loosening? ☐ Yes ☐ No

Have you previously been diagnosed with periodontal disease? ☐ Yes ☐ No

How often do you brush your teeth? ☐ 3+ times daily ☐ 2 times daily ☐ Once daily ☐ Less than once per day

How often do you floss your teeth? ☐ 3+ times daily ☐ 2 times daily ☐ Once daily ☐ Less than once per day

How would you describe the current state of your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have pain or clicking in your jaw? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Have you ever worn braces on your teeth? ☐ Yes ☐ No

Have you ever had an unfavorable reaction to anesthetic or other medication during a dental procedure?
☐ Yes ☐ No If yes, please explain: _____

Have you had any complications of any kind following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Are you happy with your smile? ☐ Yes ☐ No If no, what would you like to change? _____
_____

Do you have any other concerns or questions you would like to address with the dentist today?
_____
_____
_____
_____

Patient: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information regarding my medical and dental health and have accurately answered the questions asked of me. I understand that providing incorrect answers can be dangerous to my health. I understand that it is my responsibility to inform my dentist of any changes in my health condition. I authorize and give my consent for Spring Dental Group to perform dental services as agreed between me and my dentist to be necessary or advisable, including the use of local anesthesia and other medications indicated. I agree that I am personally liable for any and all charges for my dental treatment and that any fees not paid by my insurance (if any) become immediately due and payable by me upon denial of benefits by my insurance carrier or within 90 days after treatment is performed in the event my insurance carrier fails to make payment for whatever reason.

_____

Signature of Patient, Insured, Guardian, or Personal Representative

_____

Printed Name of Patient, Insured, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

_____ _____

Signature of Examining Dentist Date

MEDICAL INSURANCE INFORMATION

Some procedures may be covered by your medical insurance, depending on your plan, benefits, health conditions, and your dentist's diagnosis. This office will bill your medical insurance for dental procedures, if and when appropriate, in an effort to maximize your insurance benefits.

MEDICAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name _____
Subscriber Name: _____ Group # _____ Member ID: _____
Insured's Employer: _____ Insured's SS# _____
Insured's Birthdate: _____ Insured's Relationship to Patient: _____

Secondary Insurance
Insurance Co. Name _____
Subscriber Name: _____ Group # _____ Member ID: _____
Insured's Employer: _____ Insured's SS# _____
Insured's Birthdate: _____ Insured's Relationship to Patient: _____

ASSIGNMENT & RELEASE:
I certify that I and/or my dependents have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to SPRING DENTAL GROUP all insurance benefits for services rendered, otherwise payable to me, if any. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Spring Dental Group may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when I revoke it in writing.

_____
Signature of Patient, Insured, Guardian, or Personal Representative

_____
Printed Name of Patient, Insured, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

OPT OUT:
I certify that I understand Spring Dental Group will bill my medical insurance to assist me with getting my dental treatment covered, where appropriate and available. However, I choose to opt out of any potential benefits my medical insurance may offer for dental treatment and instead would like for Spring Dental Group to bill all of my dental treatment to my dental insurance and/or me personally, as set forth on page 1 of the Update Patient Information and Health History Form.

_____ _____
Signature of Patient, Insured, Guardian, or Personal Representative Date

_____ _____
Printed Name Relationship to Patient

Patient: _____

NEW PATIENT INFORMATION AND HEALTH HISTORY, CONT.

MEDICAL PROVIDER INFORMATION AND AUTHORIZATION

To provide you the most complete and comprehensive dental care, it may be necessary that we speak to your physician(s). Please provide the name, telephone number, and specialty of any physicians who we are authorized to contact to discuss your dental conditions and care.

Name of Physician: _____

Telephone Number: _____

Specialty _____

Name of Physician: _____

Telephone Number: _____

Specialty _____

Name of Physician: _____

Telephone Number: _____

Specialty _____

Name of Physician: _____

Telephone Number: _____

Specialty _____

AUTHORIZATION:

I certify that I authorize Spring Dental Group to speak with the above identified physician(s) about my dental conditions and care. I further agree that this authorization is ongoing and will only be terminated upon a signed, written notification from me to Spring Dental Group, specifically identifying physician(s) to which it applies.

_____

Signature of Patient, Insured, Guardian, or Personal Representative

_____

Printed Name of Patient, Insured, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

Patient: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SPRING DENTAL GROUP

HIPAA PRIVACY PROTECTION

Privacy Protection, Record Protection, and Retention

PRIVACY PROTECTION

The Privacy Rule, Section 164.530(c), requires that this Practice have in place appropriate policies and physical safeguards to protect patient Protected Health Information (PHI).

MINIMUM NECESSARY DISCLOSURE

This Practice's Privacy Policy discusses the "minimum necessary" standard. This rule is intended to ensure that patient PHI is used and disclosed within this Practice to the minimum necessary with regard to payment and internal operations of this Practice. The "minimum necessary" standard does not apply to PHI disclosure related to the patient's treatment and certain other authorized or legally required disclosures. Nevertheless, in carrying out all Practice activities, the staff should be prudent and use reasonable care not to unnecessarily disclose PHI incidentally to its use or in an unintended manner. In general, with regard to oral discussions of PHI, this means that Practice staff shall use good judgment when discussing patient matters to ensure that other staff members or patients who should not have certain PHI disclosed to them do not overhear these discussions.

RECORD PROTECTION

Additionally, all records and files pertaining to patients should be carefully monitored to ensure that they are not left in areas where they may be viewed by unauthorized individuals. When these documents are not being used, they are properly filed or held at the front desk for filing.

At this Practice, when a patient is waiting to be treated, the patient files may be kept in a file holder adjacent to the treatment room until the patient's treatment is completed and the patient leaves the treatment room. The patient's file should then be removed from the file holder. At the end of the day, all files are to be given to the treating doctor, as necessary, for dictation or documentation, or will be properly refiled or placed in a secure location for refiling the next day.

RECORD RETENTION

The Privacy Rule, Section 164.530(c), requires this Practice to maintain all documents required under the Privacy Rule for six (6) years from the date of its creation or the date when it was in effect last, whichever is later. State rules and various agreements and legal requirements of government and private insurers may also require similar or longer periods of document retention. Accordingly, it is this Practice's policy to retain the medical records of all its patients indefinitely. If space or storage limitations become acute, patient files may be reviewed after six (6) years to determine whether the file may be offered to the patient or destroyed under the terms of the Privacy Rule, state law, and other contractual requirements.

Patient: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____

Signature of Patient, Guardian, or Personal Representative

_____

Printed Name

_____ _____

Date Relationship to Patient

(**For Office Use Only**)

Written acknolwedgment of receipt of the office privacy policy was not obtained because:

_____ Communication barriers prohibited signing
_____ Emergency situation prevented signing
_____ Refused to sign
_____ Other (Please specify): _____

_____