Patient Information

(please fill out and email to us)

1120 Cadillac Court
Milpitas, CA 95035
tel: (408) 945 7593
www.skyedental.com

Contact Information

Last | First | MI

☐ Single ☐ Married ☐ Child ☐ Widowed ☐ Partnered ☐ Other

/ / (Date of Birth) | - - (Social Security Number) | Driver's License Number | E-mail

May we confirm furture appointments by E-mail? ☐ Yes ☐ No by text? ☐ Yes ☐ No

Street Address | City | State | Zip

( ) Home Phone | ( ) Work Phone | ( ) Mobile Phone

Employer | Address

How did you find us/Referred by? _____

Dental Insurance

Although we keep a computerized database of insurance reimbursements, it is important that you understand your benefits yourself. Please contact your insurance carrier directly. Estimated copay will be due in full at the time of services. If you have dental insurance, we will send a claim along with supporting documentation and/or x-rays to your insruance carrier on your behalf.

Dental Insurance Information

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Other

Primary Insurance

Subscriber's Name: Last | First | MI

Street Address | City | State | Zip

/ / (Date of Birth) | - - (Social Security Number) | ( ) Telephone

Subscriber's Employer | ( ) Telephone

Insurance Carrier | Group Name | Group Number | Subscriber/Insurance ID Number

Insurance's Street Address | City | State | Zip | ( ) Insurance's Telephone

Secondary Dental Insurance Information

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Other

Primary Insurance

Subscriber's Name: Last | First | MI

Street Address | City | State | Zip

/ / (Date of Birth) | - - (Social Security Number) | ( ) Telephone

Subscriber's Employer | ( ) Telephone

Insurance Carrier | Group Name | Group Number | Subscriber/Insurance ID Number

Insurance's Street Address | City | State | Zip | ( ) Insurance's Telephone

Health History

(please fill out, sign and email to us)

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We are a health centered dental practice. Thus we are concerned with your total well-being, not just your oral health. An essential part of our approach is a complete health history. Please fill out the health questionnaire below completely - even if some of the questions may not seem relevant to your dental health. Thank you!

Physician's Name (MD) _____ Date of last visit ___/___/___

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe: _____

(For Women Only) Are you pregnant? ☐ Yes ☐ No If yes, approximate due date ___/___/___

Please check if you have had any of the following:

☐Yes ☐No - Anemia
☐Yes ☐No - Shortness of Breath
☐Yes ☐No - Special Diet
☐Yes ☐No - Chem. Dependency
☐Yes ☐No - Artificail Joints
☐Yes ☐No - Skin Pain
☐Yes ☐No - Mitral Valve Prolapse
☐Yes ☐No - Fainting
☐Yes ☐No - Swollen Feet or Ankles
☐Yes ☐No - Thyroid Problems
☐Yes ☐No - Psychiatric Care
☐Yes ☐No - Heart Problems
☐Yes ☐No - Cortisone Treatments
☐Yes ☐No - Chemotherapy
☐Yes ☐No - Ulcer
☐Yes ☐No - Hepatitis
☐Yes ☐No - Liver Disease
☐Yes ☐No - AIDS

☐Yes ☐No - Cough, Persistant
☐Yes ☐No - High Blood Pressure
☐Yes ☐No - Arthritis
☐Yes ☐No - Artificial Heart Valve
☐Yes ☐No - Swollen Neck Glands
☐Yes ☐No - Asthma
☐Yes ☐No - Stroke
☐Yes ☐No - Nervous Problems
☐Yes ☐No - Glaucoma
☐Yes ☐No - Cancer
☐Yes ☐No - Tobacco Habit
☐Yes ☐No - Hemophilia
☐Yes ☐No - Respiratory Disease
☐Yes ☐No - Chest Pain
☐Yes ☐No - Circulatory Problems
☐Yes ☐No - Scarlet Fever
☐Yes ☐No - Veneral Disease
☐Yes ☐No - Other Autoimmune Dx.

☐Yes ☐No - Cough Up Blood
☐Yes ☐No - Jaw Pain
☐Yes ☐No - Kidney Disease
☐Yes ☐No - Diabetes
☐Yes ☐No - Heart Murmur
☐Yes ☐No - Epilepsy
☐Yes ☐No - Back Problems
☐Yes ☐No - Blood Disease
☐Yes ☐No - Pacemaker
☐Yes ☐No - Headaches
☐Yes ☐No - Radiation Treatment
☐Yes ☐No - Tonsillitis
☐Yes ☐No - Tuberculosis
☐Yes ☐No - Rheumatic Fever
☐Yes ☐No - High Cholesterol
☐Yes ☐No - Fibromyalgia
☐Yes ☐No - HIV

Please explain items checked YES: _____

BEFORE ANY CLINICAL PROCEDURES, PATIETNS AT RISK OF INFECTIVE ENDOCARDITIS MUST BE PREMEDICATED

_____(initials if you are a woman of childbearing age) I have been informed that any antibiotics prescribed to me will reduce the effectiveness of Birth Control Pills

List any medications you are currently taking: _____

_____

_____

Have you EVER taken or are currently taking biphosphanates (e.g. Fosamax)? ☐Yes ☐No

Have you EVER taken or are currently taking fenfluramine and phentermine (e.g. Fen-phen)? ☐Yes ☐No

ALLERGIES: ☐ Aspirin ☐ Barbiturates ☐Codeine ☐Local Anesthetics
☐ Penicillin ☐ Sulfa ☐Latex (gloves) ☐Other

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR HEALTH OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date ___/___/___ Doctor's Signature _____ Date ___/___/___

Personal Dental History

(please fill out, sign and email to us)

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Name _____

Preferred Name _____

Previous Dentist's Name _____

When was your last teeth cleaning and xrays? _____

Purpose of today's visit _____

Have you consulted with any other dentist about this? _____

If Yes, what was discussed or done? _____

_____

Do you now have or have you ever had any of the following?

☐ Yes ☐ No - Gum disease
☐ Yes ☐ No - Clicking of popping jaw
☐ Yes ☐ No - Pain around ear
☐ Yes ☐ No - Loose or broken teeth of fillings
☐ Yes ☐ No - Sore, blisters or growths

Sensitivity to:

☐ Yes ☐ No - Cold
☐ Yes ☐ No - Sweets

☐ Yes ☐ No - Grind/clench your teeth
☐ Yes ☐ No - Jaw Pain or tiredness
☐ Yes ☐ No - Lip or cheek biting
☐ Yes ☐ No - Food collection between teeth
☐ Yes ☐ No - Bad breath

☐ Yes ☐ No - Heat
☐ Yes ☐ No - Biting/Chewing

Have you had braces/orthodontics? ☐ Yes ☐ No **If yes, do you still wear a reatiner?** ☐ Yes ☐ No

Have you ever had trouble getting numb or had any reactions to local anesthetic?

Would you like to know what options are available to you to:

☐ Yes ☐ No - Create a more attractive smile
☐ Yes ☐ No -Look younger
☐ Yes ☐ No - Keep your teeth for life

_____ ___/___/___

Patient's Signature Date

To Request X-rays and Treatment Records from another Dental Office

(please fill out, sign and email to us)

1120 Cadillac Court
Milpitas, CA 95035
tel: (408) 945 7593
www.skyedental.com

To minimize your exposure to radiation, it is very important to know when you last had x-rays taken AND the type of x-rays. Please provide our office with this information prior to your appointment.

I, _____, hereby request and authorize

_____

Practice or Dentist Name

to disclose and provide copies of any and all clinical treatment records and information concerning my care, that is in the possession of this person and entity to

Skye Dental
1120 Cadillac Court
Milpitas, CA 95035
408-945-7593

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.

I expressly release from liability the above named person or entity form from any and all liability arising from compliance with this request and disclosure of the requested information.

_____ ___/___/___

Patient's or Guardian's Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This HIPAA Portion of the Acknowledgement

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

_____ _____/_____/_____

Signature Date

CANCELLATION/INSURANCE POLICY

I have read, understood and accept the terms of the outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Skye Cosmetic Dental Center. I am fully aware that I am the final responsible party for these commitments. I am also aware that any cancellations or reschedules made within 48 hours of the appointment time will result in a $50 charge.

_____ _____/_____/_____

Signature Date

CONSENT FOR TREATMENT

I hereby authorize doctor/staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ _____/_____/_____

Signature Date

For office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be acquired because: Individual refused to sign, communications barriers prohibited obtaining acknowledgement, or Other (please specify):

_____

Employee Name_____ Employee Signature_____ Date_____

Financial Policies

(for your records)

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At Skye Cosmetic Dental Center we are committed to your dental health. We are pleased that you might have insurance benefits to help you with the cost of your dental care. Your insurance policy is a contract between you and your dental insurance. Although we are not a party to that contract, we will do everything we can to help you obtain the maximum amount of benefit allowed by your insurance company. Please keep in mind that some services are not covered by your dental insurance. Our doctors make treatment recommendations based on their knowledge of what is best for you. Please do not let your insurance policy dictate your dental treatment.

Do you accept my insurance? How much will they pay?

We currently accept all private care insurance plans (PPO) that do not require you to select a dentist from a list or that use reduced fee for service program. This means we can work with thousands of insurance companies! Although we maintain a computerized history of payments made by some insurance companies, plans do change. Therefore, it is impossible to give you an absolutely guaranteed quote of what your insurance will pay at the time of service. We do provide an estimate based on the most up-to-date information, but **this is only an estimate**.

I thought I paid my portion. Why did I get a bill?

We base the patient portion of your bill on or most current information, but there are many factors that can affect this estimate. Sometimes a deductible may apply to your treatment, or you may have received services at another office prior to joining our office. Seeing a specialist for care will also reduce your annual benefits. If these or other situations apply to you, please let us know so we can adjust your benefits accordingly, and give you the best estimate possible.

Insurance companies do not (and in most cases, cannot) notify us of changes to your benefits; they only notify you. Your insurance will send you an "Evaluation of Benefit" (EOB) directly, to help you understand your patient portion.

Financial options:

We understand that everyone's financial situation is different. That is why we offer many options to help you pay your patient portion at the time of service. We accept cash, checks, and most major credit cards. If you are in need of an extended finance option, please ask one our patient care coordinators for more information.

Cancellation Policy:

We reserve your appointment time just for you, and always try to see you right on schedule. We do not double-book our patients, so when you cancel or reschedule at the last minute, it can be very difficult for us to fill this opening. This is unfair to other patients who could have used the time that you reserved. Any cancellation made within 48 hours of your scheduled appointment time will result in a $50 fee.

Welcome to our practice! We look forward to working with you and providing a pleasant dental experience!

Notice of Privacy Practices / HIPAA

(for your records)

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This notice desribes how health information from 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 took effect 03/15/2003, and will remain in effect until it is replaced.
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.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment and healthcare options. For example:
Treatment: We may use and disclose your health inforamtion to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to a obtain payment for services we provdied 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.
Public Health Activities. We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate goverment authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

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 $5.00 for each page, $50.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. These fees must be paid in advance of processing your request. 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 additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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.

Skye Dental
Attn: HIPAA Compliance Officer
1120 Cadillac Ct.
Milpitas, CA 95035
(408)945-7593

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.

Your options are as follows:

1. If you refuse to sign the consent, our practice cannot share your personal information. That means we cannot submit it to your insurance company, nor share it with other health care providers (for example, with a specialist we may wish to refer you to).

2. If you refuse to sign the consent we will ask only that you pay us in full at the time of service. You are free to submit your receipt to your insurance company for reimbursement.

Note:

- We may copy the documents you sign, or scan them into our computer
- We will give you the documents back upon request.

If you agree to give consent, please sign the **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES** along with the required patient forms.