Patient Registration and Health History Form

Today's Date: _____/_____/_____ ***How did you hear about us**? _____

PATIENT INFORMATION				
Name: LAST	FIRST	M.I.		Gender: Male ☐ Female ☐
Date of Birth: / /	Social Security #:		Email:	
Address:	City:		State:	Zip Code:
Home #: ( ) -	Cell #: ( ) -		Work #: ( ) -	

Do you have any of the following diseases or problems:	**(Check DK if you Don't Know the answer to the question**	**Yes**	**No**	**DK**
Active Tuberculosis		☐	☐	☐
Persistent cough greater than a 3 week duration		☐	☐	☐
Cough that produces blood		☐	☐	☐
Been exposed to anyone with tuberculosis		☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	Date of your last dental exam: _____			
				Date of last dental x-rays: _____			

What is the reason for your dental visit today? _____

_____

How do you feel about your smile? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Information

Are you under a physician's care now?	Yes	No	If yes, name of physician and phone number: _____
			_____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

(continued on the backside)

Are you allergic to any of the following?: Yes No

Which of the following? : Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If other, please explain:

_____

Women: **Are you Pregnant/Trying to get pregnant?** Yes No | **Taking oral contraceptives?** Yes No | **Nursing?** Yes No

Do you have, or have you had, any of the following?:

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Medical Updates

I have reviewed my Health/Dental history and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FOR COMPLETION BY DENTIST

Comments: _____

_____

_____

Miracle Smile Dentistry Los
Angeles
5850 Wilshire blvd
Los angeles
California, 90036

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Miracle Smile Dentistry Los Angeles understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 , and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages 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, mailing, 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 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 at 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: _____
Telephone: 3239327020
E-mail: carolgranados@emiraclesmile.com
Address: 5850 Wilshire blvd
Zip Code: 90036
State: California
City: Los angeles

Miracle Smile Dentistry Los Angeles -

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

First Name: _____ Date: _____

Last Name: _____ DOB: _____

I authorize to release my medical records to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone: _____ Fax: _____

I authorize to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

€ Complete Chart
€ Discharge Summaries
€ Consultations
€ Lab Work
€ X-Rays
€ Skin Tests
€ Other: _____

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature:_____ Date: _____

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

_____ First Request _____ Second Request _____ Third Request

Request for Access to Protected Health Information

Name: _____ Date of Birth:_____

Request for Access

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like Miracle Smile Dentistry Los Angeles to send a copy of my PHI to:.

Name:_____.

Address: _____.

Phone: _____ Fax: _____.

_____ I would like a summary of my requested PHI..

Description of Records or Information to Access, Copied, or Inspected:

_____

_____

Inspection Period:

I request information regarding the following time period:

From: _____/_____/_____/ To: _____/_____/_____/

Month / Day / Year Month / Day / Year

Copy Fees

I understand that Miracle Smile Dentistry Los Angeles may charge me for making copies of my PHI. Miracle Smile Dentistry Los Angeles may charge me 25 cents per page of PHI photocopied.

Your Rights Regarding This Request

- I understand that I must be provided with a signed copy of this document.
- I understand that Miracle Smile Dentistry Los Angeles may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Miracle Smile Dentistry Los Angeles will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature:_____Date: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:_____Relationship:_____

5850 Wilshire Boulevard
Los Angeles, CA 90036
T. 323-932-7020
F. 323-23-2-7023

Patient Financial Agreement and Consent

We are committed to providing you with the best possible dental care. If you have dental insurance, we will help you to receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our financial policy.

For your convenience, we accept all major credit cards. We deliver the finest care at the most reasonable cost to our patients; therefore, payment is due at the time service is rendered. There is a $35 fee for a returned check. **Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. Any remaining balance after your insurance has paid is your responsibility.** Your prompt remittance is appreciated. We do offer financing through CareCredit, and also offer an in-office payment arrangement which requires a down payment of 33% down payment and a 5% processing fee.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, we would like for you to understand the following:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Dental insurance is not meant to be a pay-all: it is only meant to be an aid. Many routine dental services are not covered by dental insurance at all. If you should have any questions regarding your coverage, you should contact your company regarding the details of the plan that is conducted on your behalf. It is your responsibility to know your insurance coverage.
3. Many plans tell you, you will be covered “100%”. In spite of what you are told we have found that most plans only cover approximately 50-80% of an average fee. It has been our experience that some insurance companies tell their customers that “fees are above the usual and customary” rather than saying “the benefits are low”.
4. We give our patients the option to upgrade their crowns, bridges and other prosthetics to a premium material and lab for a cost of $250- $500 as determined by their dentist. This is not a covered procedure by your insurance company and you are responsible for the cost.

We must emphasize that as dental care providers, our relationship is with you, NOT your insurance company.

While the filing of all insurance claims is a courtesy we extend to our patients, all charges are your responsibility.

I _____ hereby authorize payment of the dental benefits otherwise payable to me directly to Miracle Smile Dentistry. I understand and agree that, regardless of any insurance coverage, I am responsible for the entire balance on my account for any professional services rendered.
All financially responsible parties must sign this form, whether you have insurance or not.

_____ _____

SIGNATURE **DATE**