SPRING DENTAL GROUP
LONG BEACH, CALIFORNIA

WELCOME!

Thank you for trusting Spring Dental Group with your dental care! Our goal is to provide our patients with the highest quality dental care at the most affordable cost. Please help us by completing this form.

PATIENT INFORMATION

Patient Name: _____ Date: ___/____/_____

Sex: **M F** ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: ___-___-_____ Birth Date: ___/___/_____

Phone (Home):_____(Work) _____Ext:_____Best Time: _____

Cell Phone: _____Email: _____

Address: _____Apartment # _____

Who may we thank for referring you to our office? _____

Nearest relative not living with you: _____
Name/Relationship to patient

_____
Address Telephone

EMPLOYMENT/ 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: _____

For Patients with Insurance:

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

I prefer to receive communications from the office

On: [ ] Home Phone [ ] Work Phone [ ] Cell phone

By: [ ] Text message [ ] Email [ ] Voice Mail [ ] other _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

_____

Name Relationship to patient

_____

Address Telephone

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

EMERGENCY CONTACT INFORMATION

_____

_____

Name Relationship to patient

_____

Address Telephone

HEALTH INFORMATION

□ Yes	□ No	Allergies	□ Yes	□ No	Growths/Tumors	□ Yes	□ No	Pacemaker
□ Yes	□ No	Diet Pills/Fen-Fen	□ Yes	□ No	HIV/ AIDS	□ Yes	□ No	Penicillin Allergy
□ Yes	□ No	Anemia	□ Yes	□ No	Hay Fever	□ Yes	□ No	Radiation Treatment
□ Yes	□ No	Arthritis	□ Yes	□ No	Head Injuries	□ Yes	□ No	Respiratory
□ Yes	□ No	Artificial Joints	□ Yes	□ No	Heart Disease	□ Yes	□ No	Rheumatic/Scarlet Fever
□ Yes	□ No	Asthma	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Sinus Problems
□ Yes	□ No	Blood Disease	□ Yes	□ No	High/Low Blood Pressure	□ Yes	□ No	Stomach Problems
□ Yes	□ No	Bleeding	□ Yes	□ No	Hepatitis: A B C	□ Yes	□ No	Stroke
□ Yes	□ No	Cancer	□ Yes	□ No	Joint Replacement	□ Yes	□ No	Thyroid
□ Yes	□ No	Codeine Allergy	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Tuberculosis
□ Yes	□ No	Corrective Lenses	□ Yes	□ No	Latex Allergies	□ Yes	□ No	Ulcers
□ Yes	□ No	Diabetes: Type: I II	□ Yes	□ No	Liver Disease	□ Yes	□ No	Venereal Disease
□ Yes	□ No	Epilepsy	□ Yes	□ No	Methamphetamine Use	□ Yes	□ No	Use Tobacco
□ Yes	□ No	Fainting	□ Yes	□ No	Nervous/Mental Disorders	□ Yes	□ No	Women: **Pregnant**
□ Yes	□ No	Glaucoma	□ Yes	□ No	Osteoporosis Medication	□ Yes	□ No	Due date: ___/___/____

Do you have any allergies? □ Yes □ No If Yes please list: _____

_____

Do you have any sensitivity to metals? □ Yes □ No

Do you have or have you experienced the following?

□ Yes □ No Shortness of breath on mild exertion
□ Yes □ No Chest pains after/during exertion
□ Yes □ No Swollen ankles
□ Yes □ No Emotional problems, stress, or tension which cause you concern
□ Yes □ No A tumor or abnormal growth

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

Name of Physician: _____Telephone#: _____

Please list all current medications (including over-the-counter, vitamins, supplements, etc.)

_____

_____

_____

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+ per day □ 2 per day □ 1 per day □ Less than 1 per day

How often do you floss your teeth? □ 3+ per day □ 2 per day □ 1 per day □ Less than 1 per day

How often do you see a dentist? □ Every 6 months □ Once a year □ Less than once a year

When was you last dental appointment? _____

Name of Former Dentist _____

Address of Former Dentist _____

What is your current state of oral health? □ Excellent □ Good □ Fair □ Poor

Do you have pain or clicking in your jaw? □ Yes □ No Do you grind your teeth? □ Yes □ No

Do you wear full or partial dentures? □ Yes □ No
If yes, Upper? □ Yes □ No Lower? □ Yes □ No For how long? _____

Have you ever had dental implants placed? □ 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? _____

_____

AUTHORIZATION & 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 if I ever have a change in my health. 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 or my dependent's dental treatment. If my insurance (if any) fails to make payment for any reason any balance remaining more than 90 days after treatment is performed will become immediately due and payable.

____
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 and Dental History Update

I have read my medical history dated ___________ and confirmed that it accurately states my past and present conditions. ______________________ ______________________
Patient Signature Date Dentist Signature Date

I have read my medical history dated ___________ and confirmed that it accurately states my past and present conditions. ______________________ ______________________
Patient Signature Date Dentist Signature Date

I have read my medical history dated ___________ and confirmed that it accurately states my past and present conditions. ______________________ ______________________
Patient Signature Date Dentist Signature Date

I have read my medical history dated ___________ and confirmed that it accurately states my past and present conditions. ______________________ ______________________
Patient Signature Date Dentist Signature Date

I have read my medical history dated ___________ and confirmed that it accurately states my past and present conditions. ______________________ ______________________
Patient Signature Date Dentist Signature Date

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 the 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 or oral 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 as necessary are to be given to the treating doctor for dictation or documentation or will be properly refilled or placed in a secure box for refilling the next day.

Record Retention

The Privacy Rule, Section 164.530(j) requires this Practice to maintain all documents required under the Privacy Rule for 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 of its patients indefinitely. If space or storage limitations become acute, patient files may be reviewed after 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.

Acknowledgement of Receipt of Notice of Privacy Practices

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

Signature: _____ Date: _____

If a patient is a minor, parent or guardian please complete the following:

Parent or Guardian's name:

_____Relationship:_____

Authorization to Release Information

I, **Test Test** , authorize the following person(s) to have access to information protected under the HIPAA privacy practice regarding my healthcare information and/or my relevant financial information (including, but not limited to, the cost of services, insurance payments, private payments, and account balance).

1. Person authorized:_____Date:_____

2. Person authorized:_____Date:_____

Signature:_____Date:_____

Printed Name:_____

(For Office Use Only)

Written acknowledgement 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):_____

_____