UPTOWN DENTAL

PATIENT INFORMATION

FULL NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARTIAL STATUS: _____

SOCIAL SECURTIY NUMBER: _____ EMAIL: _____

ADDRESS: _____
(home) (street) (city) (state) (zip)

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____
(home) (street) (city) (state) (zip)

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMERGENCY CONTACT #: _____

HOW DID YOU HEAR ABOUT US? _____

DENTAL INFORMATION

NAME OF FORMER DENTIST: _____ LAST VISIT DATE: _____

ADDRESS OF FORMER DENTIST: _____ PHONE: _____

REASON FOR TODAY'S VISIT: _____

IF YOU HAVE INSURANCE(S), PLEASE COMPLETE THE FOLLOWING:

INSURED PERSON: Patient [ ] Spouse [ ] Parent [ ]

SUBSCRIBER NAME: _____

BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____

INSURANCE: _____

INSURANCE PHONE: _____

GROUP #: _____ UNION LOCAL: _____

INSURED PERSON: Patient [ ] Spouse [ ] Parent [ ]

SUBSCRIBER NAME: _____

BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____

INSURANCE: _____

INSURANCE PHONE: _____

GROUP #: _____ UNION LOCAL: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

PERSON RESPONSIBLE FOR PAYMENT

FULL NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ SOCIAL SECURTIY NUMBER: _____

ADDRESS: _____
(home) (street) (city) (state) (zip)

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

MEDICAL INFORMATION

NAME OF Medical Doctor/Office: _____ LAST EXAM DATE: _____

ADDRESS OF Medical Doctor/Office: _____ PHONE: _____

DO YOU CURRENTLY EXPERIENCE OR HAVE ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Chest pain (angina)	[ ]	[ ]	Stroke, hardening of arteries	[ ]	[ ]
Swollen ankles	[ ]	[ ]	High blood pressure	[ ]	[ ]
Shortness of breath	[ ]	[ ]	Prosthetic heart valve	[ ]	[ ]
Recent weight loss, fever, night sweats	[ ]	[ ]	Pacemaker, implanted defibrillator	[ ]	[ ]
Persistent cough, coughing up blood	[ ]	[ ]	Asthma, TB, emphysema	[ ]	[ ]
Bleeding problems, bruising easily	[ ]	[ ]	Hepatitis, other liver disease	[ ]	[ ]
Sinus problems	[ ]	[ ]	Stomach problems, ulcers	[ ]	[ ]
Difficulty Swallowing	[ ]	[ ]	Psychiatric care	[ ]	[ ]
Diarrhea, constipation, blood in stools	[ ]	[ ]	Radiation treatments	[ ]	[ ]
Frequent vomiting, nausea	[ ]	[ ]	Chemotherapy	[ ]	[ ]
Difficulty urinating, blood in urine	[ ]	[ ]	Artificial joint(s)	[ ]	[ ]
Excessive thirst, frequent urination	[ ]	[ ]	Dizziness, headache, fainting spells	[ ]	[ ]
Diabetes	[ ]	[ ]	VD (syphilis or gonorrhea), herpes	[ ]	[ ]
HIV/ AIDS	[ ]	[ ]	Kidney, bladder disease	[ ]	[ ]
Recreational Drugs	[ ]	[ ]	Skin disease, eye disease	[ ]	[ ]
Heart Disease	[ ]	[ ]	Thyroid, adrenal disease	[ ]	[ ]
Heart attack, heart defects	[ ]	[ ]	Tobacco in any form	[ ]	[ ]
Heart murmurs	[ ]	[ ]	Alcoholism	[ ]	[ ]
Rheumatic fever	[ ]	[ ]	Surgeries, blood transfusions	[ ]	[ ]

	YES	NO
Are you in pain now?	[ ]	[ ]

If yes, where and how? _____

Have you been hospitalized or had a serious illness within the last three years?	[ ]	[ ]

If yes, why? _____

Has there been a change in your health within the last year?	[ ]	[ ]

If yes, what? _____

Are treated by a physician now?	[ ]	[ ]

If yes, what? _____

Do you have allergies (to drugs, foods, medication, latex, penicillin, etc.)?	[ ]	[ ]

If yes, what? _____

Are you taking Fosamax, Aredia, Zometa, Bondronat, or Actonel?	[ ]	[ ]

List all medications you are taking: _____

If you require pre-medication (antibiotics, sedatives) prior to treatment, please list: _____

Please describe any unfavorable dental experience you have had: _____

_____

ACKNOWLEDGEMENT AND CONSENT

I consent to the treatment as necessary for the patient named above, including but not limited to any medications such as anesthetics, analgesics, antibiotics, antiseptics, x-rays, laboratory work that may be used, dispensed, or prescribed by the attending doctor, or his assistants. I authorized the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I also acknowledge full responsibility for the payment of such services and agree to pay in full the portion not covered by my insurance, at the time of service, unless financial agreement is made prior to service.

SIGNATURE: _____ **DATE:** _____

patient, parent, or guarantor (must be 18 or older)

THERE IS NO CHANGE TO MY MEDICAL HISTORY AS STATED ABOVE

DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____

DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____

DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____

Uptown Dental

Dear Patients,

Welcome to our office! We truly appreciate you choosing Uptown Dental to give you the care and attention needed to maintain your oral health. It's our desire to provide you with exceptional care in a comfortable and personal atmosphere. Please review our office policies below, describing what we ask and expect from our patients.

1- Payment in full is expected for services rendered at each visit. This includes any emergency treatments needed.

2- If you need to cancel or reschedule an appointment, **please notify the office 48 hours before your appointment date. Otherwise, the appointment will be considered broken and an $80.00 fee will be charged.** Broken appointments must be paid in order to schedule another appointment.

3- Three broken appointments will result in patient termination. At this time, no further appointments will be scheduled.

4- If extensive treatment is needed (e.g. root canals, crowns, bridges, partial or full dentures) we require half-payment prior to beginning treatment. The remaining balance must be paid in full on day of delivery.

5- No recall appointments will be scheduled until outstanding balances have been paid in full, unless a payment plan has been arranged.

6- It is understood that I am fully responsible for any balance not paid by my insurance company.

By signing, I acknowledge that I have read and agree to the terms and conditions above.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____

UPTOWN DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW THE BELOW INFORMATION CAREFULLY. THE PRIVACY YOU'RE 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 9/1/2017 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 law. We reserve the right to make the changes in our private 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 any 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, evaluation 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.

UPTOWN DENTAL

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' 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 communication 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.

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 out 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 use using the contact information listed at the end of this Notice. Y79ou 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.

Contact Officer: Christopher Thomas

Telephone: 510-893-4321 Fax: 510-893-4323

Email: uptown.oakland.dental@gmail.com

Address: 1716 Telegraph avenue Oakland CA 94612

UPTOWN DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

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

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

_____

_____

_____

UPTOWN DENTAL

DENTAL MATERIAL FACTS SHEET

To ensure that the public is aware of the most current research information regarding the use of materials for dental restoration, the Dental Board of California has prepared a Dental Material Fact Sheet that has been distributed to all dental practitioners in the state. This fact sheet defines the most common dental restorative materials, their uses, and the characteristics of each. As a patient of Uptown Dental, you may at some time have restorative treatment recommended with one or more of these materials. The dental office will recommend procedures and materials which we feel best fit your needs. Restorative procedures include fillings (silver and tooth-colored), crowns, partial dentures, full dentures and veneers. We encourage you to review the information contained in this fact sheet carefully and discuss any questions or concerns you may have with your dentist before undertaking the restorative procedure.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received the Dental Material Fact Sheet developed by the Dental Board of California. I understand that this fact sheet has been provided to me in an effort to ensure I am fully informed of the materials available for dental restorations. I understand that I should review this information to make fully informed decisions regarding dental restoration treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with my dentist before undertaking any restoration care.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

The "Facts about Fillings" pamphlet can be referenced at the following Dental Board of California web address:

https://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf

UPTOWN DENTAL

For Your Information:

Estimate of insurance benefits is **NOT** a guarantee of payment by your insurance carrier. This estimate has been calculated based on currently available benefits and patient eligibility. The amount is subject to change based on: remaining benefits available, deductibles, fee schedule of benefit changes, coordination of benefits and/or lack of patient eligibility at the time services are provided or any outstanding prior claims that have not been cleared by insurance yet. All of these factors can affect the estimate; therefore the estimate may differ from the final insurance payment.

Patient is responsible for all fees not covered or paid by the insurance carrier. Any overpayment will be returned to patient.

Thank you for your cooperation.

Patient(s) and/or guardian has/have read the above information

Patient/Guardian Signature: _____