PATIENT INFORMATION FORM

Kensington Natural Smiles

We would like to welcome you to Kensington Natural Smiles, the office of Dr. Susan Ho and Team!

Please enter all the information requested.

Today's Date:

Who may we thank for referring you to our office?

Name (Last, First, Middle): Title:

Address:

E-mail Address:

Preferred contact (email, home phone, work phone, cell phone):

Home Phone: Work Phone: Cell Phone:

Sex: Marital Status: Social Security No.: DOB:

Medical Alerts:

Employer:

Employer's Address:

Name of Insured: Relationship to Patient:

Social Security No.: DOB:

Insured Employer:

Address:

Insurance Company:

Insurance Address:

Insurance Phone No.: ID No.: Group No.:

In case of an emergency who may we contact?

Relationship: Phone No.:

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now?	☐ Yes ☐ No	If yes, please explain:	
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		
Have you ever taken Fosamax, Boniva, Actonel or any Other medications containing bisphosphonates?	☐ Yes ☐ No		
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		
Do you use controlled substances?	☐ Yes ☐ No		

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT QUESTIONNAIRE

Name:

Please check YES or NO to the following and fill in details:

YES	NO	
☐	☐	Are you happy with your smile?
☐	☐	Are you presently in any pain?
☐	☐	Have you ever experienced any unfavorable reaction to dentistry?
☐	☐	Have you lost any teeth? From what cause?
☐	☐	Have you ever had orthodontic treatment? When?
☐	☐	Is there any change in the way your teeth fit together when you bite?
☐	☐	If you have them, is there any change in the fit of your partial dentures?
☐	☐	Do you have any growths or swellings in your mouth? How long have they existed?
☐	☐	Do you have any difficulty swallowing?
☐	☐	Do your gums bleed when brushing or using a toothpick?
☐	☐	Are your gums red, swollen, or tender?
☐	☐	Do you avoid brushing any part of your mouth? Why?
☐	☐	Are your gums pulling away from your teeth?
☐	☐	Have you ever been told you have gum disease? When?
☐	☐	Do you see pus between your teeth and gums when they are pressed?
☐	☐	Is any part of your mouth sensitive to temperature, pressure or food or drink? What?
☐	☐	Do you have a burning sensation in your mouth?
☐	☐	Have you ever had a bad reaction to dental anesthetic? When?
☐	☐	Does food catch between your teeth?
☐	☐	Are your permanent teeth loose or separating?
☐	☐	How often do you floss? How often do you brush?
☐	☐	Do you have any pain or soreness around your eyes or ears or other parts of your face? When?
☐	☐	Are you aware of stiff neck muscles? How often?
☐	☐	Do you ever awaken with an awareness of your teeth or jaws? How often?
☐	☐	Are you aware of clenching your teeth during the day? How often?
☐	☐	Have you ever been told you grind your teeth while sleeping? How often?
☐	☐	Are you aware of your jaw clicking or popping while eating or yawning? How often?
☐	☐	Do you have difficulty opening your mouth widely?
☐	☐	Do you have "tension" headaches? How often?
☐	☐	Do you have an unpleasant taste or odor in your mouth?

NOTICE OF PRIVACY PRACTICES

OUR OBLIGATIONS: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Except for the purposes described below, we will use and disclose Health Information only with your written permission.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to confirm an appointment with us.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIALSITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. In the case of a breach of unsecured protected health information, we will notify you as required by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. We may release Health Information to funeral directors.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT:

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:
The following uses and disclosures of your Protected Health Information will be made only with your written authorization: uses and disclosures of Protected Health Information for marketing purposes; and disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances.
Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.
Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must make your request, in writing.
Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.
Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing. *Right to a Paper Copy of This Notice*. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our web site or ask us for a paper copy.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint you must contact our office. All complaints must be made in writing. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

_____ _____ _____
Print Name Signature Date

I authorize the office to discuss personal treatment and finances with the following individual(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Patient signature Date

FINANCIAL AGREEMENT

Thank you for choosing Kensington Natural Smiles for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Payment in full is due at the time of service unless prior financial arrangements are made.
We offer several payment options:

- Cash, Checks, Visa, Master, and Discover Cards
- Pre-payment discounts
- Care Credit

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. After your treatment services have been submitted, please allow up to 30 days to receive your direct reimbursement from your insurance company. If you have any questions, our courteous staff is always available to answer them.

Missed Appointments

When we schedule your appointment, the time is reserved exclusively for you. When you failed to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an appointment. We reserve the right to charge $50 for all canceled or missed appointments without 24-hours notice.

Service Charge

1. Monthly Billing: Even though an insurance claim has been filed, you will received a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. 1.5% service charge will be applied every month to accounts with balances outstanding 30 days or longer, regardless of outstanding insurance unless a prior financial arrangement was made.
2. Returned Checks: There is a $30 fee for returned checks.
3. Collection Fees: $30 fee will be assessed for each account sent to collection. I herby agree to pay all courts cost, additional collection fees and attorney's fee.
4. All record duplication will be assessed a $20 fee.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for all services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of patient, parent, guardian, or personal representative Date

_____ _____

Name of patient, parent, guardian, or personal representative Relationship to patient

Kensington Natural Smiles

Today's Date: _____

Name: _____

When Considering having treatment done which of these would be of concern to you?

Fear

Time

Budget

No sense of urgency

As providers all the following are important to us, but which is most important to you?

Function

Comfort

Cosmetic

Longevity

What is the most important quality for you in a relationship with your Doctor?

_____

_____